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DR. FORDYCE'S CASE OF IDIOPATHIC MULTIPLE PIGMENTED SARCOMA OF THE SKIN.

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MULTIPLE PIGMENTED SARCOMA OF THE SKIN (KAPOSI).

BY J. A. FORDYCE, M.D.

TYPICAL examples of this affection are sufficiently uncommon to justify me in placing the following case upon record:

The patient, R. B., is a muscular Italian sailor, of medium height, energetic and intelligent, who had been six weeks in America when he came under my observation in September, 1890. He is not addicted to the excessive use of alcoholic drinks. He has been married twice and has a family of healthy children.

About fifteen years ago he had several attacks of malarial fever; in 1862 he had gonorrhœa; in 1876, a venereal sore followed by a suppurating bubo. Twelve years ago, in Malta, he claims to have had quite a profuse hemorrhage from the dorsum of the right hand, which recurred at about the same period for several years, and was not preceded by an injury or a lesion of any kind. His present affliction began two years ago last May, and is attributed by him to a mental shock. He returned home from a voyage and found that his wife had just died from an acute malady. The shock was so great that he lost consciousness. Within a day or two he had attacks of bleeding from the nose, which continued at intervals for some weeks; at the same time he noticed when he rubbed or washed his lips that bleeding took place from them.

On the cessation of these hemorrhages, a few weeks after the mental shock mentioned, he noticed the presence of dark red spots on the calf of the left leg, followed within a day or two by the same appearances on the left thigh, then on the right leg and thigh, and finally on the right and left arms and hands similar tumors appeared. When first seen the tumors were of lighter color than at present, but no change in their size has taken place. Itching has been noticed at times, and now and then is a distressing symptom. In less than one

week after the tumors were noticed on the calf of the left leg all of the others had developed in the order named, and no additional ones appeared until about six weeks ago, when an elevated bluish-red growth developed on the dorsum of the right hand near the ulnar side. Since the onset of his skin eruption he has had no hemorrhages from the nose, lips, or from any mucous membranes. His general health has continued fairly good, but he says that he has lost in weight; to what extent, however, he is unable to state.

During the four months in which I have observed him he has been engaged in selling fruit and working as a day laborer on the streets.

After a day of hard work, I have noted that his hands and feet were markedly œdematous and that their local temperature was elevated. He says that he has not the endurance that he once had, but yet considers himself capable of doing ordinary work.

Present Condition.—On stripping the patient the tumors are seen to be confined to the extremities, the face, neck, and trunk being quite free from them. They are limited, moreover, to certain definite portions of the extremities, extending upward, somewhat beyond the middle third of the thighs, and not beyond the lower half of the upper arms. The almost symmetrical arrangement of the growths is a feature which strikes the observer at a glance, the tumors on one half of the body having almost their counterparts on the other half.

On the left side they are somewhat more numerous and larger than upon the right, this being especially noticeable upon the forearm. The symmetry of the disease is shown in the accompanying colored plate, though illustrated better in the patient, as some of the less pigmented spots are not well shown.

On the dorsal surfaces of both feet narrow bands of bluish-black infiltration, from five to seven centimetres in length, are to be seen, and a diffused infiltration is noticeable on the posterior and outer aspect of the left ankle. The dorsal surfaces of the hands and fingers are the seat of numerous nodular masses, dark blue in color, and on the ulnar side of the right palm a tumor one centimetre in diameter with two or three smaller ones are seen, looking not unlike a papulo-squamous syphilide. The growths vary much in shape, size, color, and consistency; on the legs they are darker, many being almost black, and retaining their color upon pressure. On the anterior aspects of the legs and thighs, farther removed from the extremities, their color is more reddish-brown. The darker tumors on the posterior aspects of the legs and thighs are irregularly oval in outline, firm and somewhat elastic in consistence, and show in places a distinct central depression with slight scaliness, as if in the process of involution. At the periphery of some of these depressed patches more recent nodules of a lighter color are seen, as if the disease were starting

afresh. The growths in general are firmly situated in the cutaneous tissue, movable with the skin and not very sharply defined. On the hands and arms the disease has more the character of a diffused infiltration, though showing distinct nodular formation at the periphery and over many of the patches. Both wrists are almost encircled by bands, three to four centimetres wide, of this nodular infiltration, and several narrower bands extend transversely across the forearms. The tumors here are, as a rule, more elevated than those upon the legs, their color varying from a brownish-red to a dark purple, and fading slightly upon firm pressure. The epidermis is glossy in places, as if from over-distention, and the tumors look not unlike angiomata. No evidence of past or present ulceration could be seen in any of the growths. Many of the tumors on the lower extremities impressed one as having passed their active period of growth; while those upon the hands and arms appeared to be in a more early stage of development. The tumors are slightly painful to touch.

The inguinal and epitrochlear glands were enlarged to about the size of a small marble, quite hard and oval in outline.

No abnormality could be detected in the heart or abdominal organs, and the urine was found to be quite normal.

Histology.—The recent tumor from the dorsum of the right hand and a portion from a patch on the right forearm were removed by the cutaneous punch, hardened in alcohol, and stained in a variety of ways; with borax-carmine, hæmatoxylon and eosin, hæmatoxylon and picro-carmine, and with safranine.

The best results were obtained from the combination of hæmatoxylon and picro-carmine, which gave a beautiful double stain, the cell nuclei being colored by the hæmatoxylon, while the intercellular substance was rendered visible by the diluted picro-carmine.

In the epidermis the only changes noted were a slight thickening of the horny layer, a deep pigmentation of the cylindrical cells of the rete; the papillæ were not well defined, and nowhere was there any ingrowth or proliferation of the rete cells. The cutis and subcutaneous tissue were replaced by a new growth which extended from one-fourth to one-half a centimetre below the surface. It began directly under the epidermis and was lost in the subcutaneous connective tissue. Under a low power the structure of the tumor is seen to be composed of small fusiform cells arranged in bundles extending longitudinally, transversely, and obliquely; their transverse sections looking not unlike round cells.

A striking feature of the microscopic picture was the large number of blood-vessels, around and between which are grouped the spindle cells of the tumor simulating very closely the structure of recent

cavernous angiomata. The endothelium of some of the vessels had undergone active proliferation, showing several concentric layers of round cells.

In one vessel whose calibre was almost obliterated, the several innermost layers were made up of round cells, while without these, but still in the vessel's walls, the cells became elongated and finally spindle-shaped.

In a number of these cells, as well as in the spindle-cells of the growth, the karyokinetic figures could be seen. Blood-pigment and partially degenerated corpuscles were found in the walls of the blood-vessels and scattered throughout the section.

Other blood-vessels showed exceedingly thin walls, while yet others seemed to have no proper walls, but communicated directly with the cells of the tumor.

The enormous number of blood-vessels within the growth, with their peculiar structure, accounted for the occurrence of the blood-pigment and degenerated red corpuscles, as well as for the variety of colors presented clinically by the tumors.

The pigmentation of the tumors is not to be ascribed to the presence of pigment granules within the cells, as in the true melanotic sarcomata, which originate from pigment moles or the choroid coat of the eye, but is due altogether to the hemorrhages mentioned.

The result of my examination accords closely with that of Kalindero and of Babes,[1] of a similar case in which the authors were disposed to look upon the growths as vascular in origin.

The same view is upheld by Babes[2] in an elaborate article upon the development of the sarcomatous affections.

The almost simultaneous occurrence of the tumors on the four extremities, their independence of a primary growth, and their close resemblance to other infectious diseases, as leprosy and syphilis, have suggested to more than one observer that they might owe their development to some infection which had gained entrance to the general circulation.

Pringle[3] in the discussion of the subject before the *Congrès International de Dermatologie et de Syphilographie*, held at Paris in 1889, announced that in two cases of the affection he had found bacilli which were situated in the capillaries, and in one of the cases the bacilli were found in great numbers in the sweat-glands and their ducts. Stimu-

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[1] Sarcome cutané pigmentaire multiple idiopathique, avec début par les extrémitiés.

[2] "Handbook of Skin Diseases." Edited by Ziemssen. Am. trans. New York: Wm. Wood & Co.

[3] Comptes Rendus. Paris: G. Masson, 1890.

lated by this announcement by Pringle, I stained a number of sections after the method of Gram and in various ways with the aniline dyes, but without finding micro-organisms of any kind.

The clinical history and microscopic examination in my case showed it to be a sarcomatous affection and to belong to the special variety which was first described as a distinct affection by Kaposi,[4] under the name of multiple pigmented sarcoma of the skin. He gave the histories of five cases in his original communication, all of which proved fatal, and in two of them a microscopic examination showed the tumors to be small round-celled sarcomata. An autopsy in one of the fatal cases revealed metastatic tumors in the internal organs. Treatment was without avail in these cases, and the writer states that a fatal termination is inevitable.

In a later work[5] Kaposi states that he has seen in all twelve cases of this affection, and that internal medication or extirpation of the tumors have proven unavailing in checking the fatal course of the malady.

Following Kaposi's description, other cases of this affection have been described by Vidal,[6] Wigglesworth,[7] Tanturn,[8] Taylor,[9] Amicis,[10] Köbner,[11] Hardaway,[12] Hallopeau,[13] Funk,[14] Schwimmer,[15] Köbner.[16]

The subject of sarcomatous affections in general has been fully and ably considered in a recent work by Perrin,[17] which treats of the various forms of the disease, their differential diagnosis, and relationship to allied affections.

The minute structure and clinical course of this affection would certainly ally it to the sarcomata, but it must be looked upon as an affection having marked characteristics of its own, among which may be mentioned the simultaneous appearance of symmetrical tumors on the extremities, apparently independent of a primary growth, the slight tendency of the growths to soften, and the slow course of the malady.

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[4] "Diseases of the Skin." Hebra and Kaposi. New Sydenham Society translation. London, 1875.

[5] "Pathologie und Therapie der Hautkrankheiten." Dritte Auflage. Wien, 1887.

[6] Soc. de Biologie, 1875.

[7] Arch. of Dermatology. New York, 1876.

[8] Il Morgagni. 1877.

[9] Arch. of Dermatology. New York, 1875.

[10] Il Morgagni. Napoli, 1882.

[11] Köbner, Berliner klin. Wochschr., No. 2, 1883.

[12] Journal of Cutaneous and Venereal Diseases. New York, 1884.

[13] Revue des Sciences méd., 1885.

[14] Monatsh. f. prakt. Dermat., 1889.

[15] "International Atlas of Rare Skin Diseases," II. Hamburg and Leipzig: Leopold Voss, 1889.

[16] Demonstration of a Case of Idiopathic Multiple Pigmented Sarcoma of the Skin (Kaposi). International Medical Congress, Berlin, 1890.

[17] "De la Sarcomatose Cutanée." Paris: G. Steinheil, 1886.

The affection described by various writers under the names of mycosis fungoides, mycosis fongoïde of Alibert, granuloma fungoides, and the inflammatory fungoid neoplasm of Duhring, regarding the nature of which so many divergent views have been expressed, has undoubted clinical relationship with the sarcomata, but can readily be differentiated from this affection by its primary stage of eczema and pruritus preceding the tumor development, the marked disposition of the growths to undergo softening and ulceration, and from their histological structure. The relationship of either mycosis fungoides or multiple pigmented sarcoma with a leucæmic affection of the lymphatic tissue of the skin, described by Kaposi as lymphodermia perniciosa, cannot be regarded as established, inasmuch as this latter affection was found by him in connection with an absolute increase of the white blood-corpuscles and with leucæmia of the spleen and bone marrow.

Prognosis.—The majority of the cases of this form of sarcoma of the skin have terminated fatally within from two to five years, but whether the disease is uniformly fatal, as considered by Kaposi, would hardly seem to be warranted after an examination of the cases recorded.

Hardaway,[18] under the title of a case of pigmented neoplasm of the skin, reported the case of a patient who had at that time multiple tumors of the skin, proven, by a microscopic examination by Dr. Hertzmann, to be alveolar sarcomata, which had existed for ten years without materially influencing the health of the patient. In a further report of this case[19] Hardaway says that after fifteen or sixteen years from the beginning of his disease he remains in good health, and that the sarcomatous tumors have undergone complete involution, leaving behind merely an atrophic condition of the skin.

Taylor[20] reported the cases of a colored woman, aged forty-eight, who had multiple pigmented tumors over the abdomen, extremities, palms, soles, and scapular region, in whom the first growth had appeared twenty-four years before over the sternum. The patient's health was good. No opportunity was afforded for microscopic examination, but clinically the tumors were regarded as corresponding to those in Kaposi's disease.

Köbner[21] reported a case of the disease under consideration in a girl aged eight years, in whom several hundred tumors were scattered over the extremities and trunk. After the hypodermic use of Fowler's solution for a period of several months, all the tumors under-

[18] JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, January, 1883.
[19] JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, Jan., 1890.
[20] Loc. cit. [21] Loc cit.

went complete involution, leaving behind depressed pigmented scars, which afterward became white.

An examination proved the disease to be a spindle-celled sarcoma.

At the end of five years Köbner[22] showed the case before the Berlin Medical Society, she having remained entirely free from the affection during this time.

While it would appear from the cases just quoted that an absolutely unfavorable prognosis need not be given, it should be remembered that Kaposi, who has seen more cases of this affection than any other observer, has been unsuccessful in obtaining results from the use of arsenic. The true nature of the entire group of diseases classed as sarcomata is so little understood that it would not be surprising if certain cases, which clinically presented similar or identical features, should prove to originate from independent causes.

The patient whose case is described in this paper has been under my close observation for a period of four months, during which time I have given him arsenic both hypodermically and internally, without noting any special action of the drug on the disease. No additional tumors have developed, and the patient's general condition has remained unchanged.

66 Park Avenue.

ON PSOROSPERMOSIS FOLLICULARIS.[1]

By Dr. SIGMUND LUSTGARTEN,
Of New York.

THE case which I wish to report is in many respects one of great interest. It would be of little value to go back far in the literature for the purpose of seeking in a mass of designations examples of this disease. It has certainly been repeatedly seen, as may be said of all new diseases, and instances of it may certainly be found under the designations ichthyosis sebacea, sauroderma (Wilson), acne sebacea cornea, ichthyosis follicularis, cacotrophia follicularis (T. Fox); but since these reports lack the microscopic examination which would have explained the cases, the observations are almost without exception worthless.

The new history of the disease begins with a case of Prince A. Morrow[2] of keratosis follicularis; further, a case described under the

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[22] Berl. klin. Wochenschrift, No.12, 1886.

[1] Paper read before the Tenth International Congress, in Berlin.

[2] Journ. of Cut. and Vener. Dis., Sept., 1886.

same name by Dr. James C. White,[3] who later added a second case[4] (father and daughter) after Darier's communication. From this it seems doubtful whether Morrow's case (a photograph of which I am enabled to present, through the kindness of Dr. Piffard) really belongs here, the more since Dr. Robinson, who made the microscopic examination, says nothing of psorospermia or of any similar formation. No such objection can be made to White's cases, since psorospermia were found by Dr. John T. Bowen after Darier's discovery. The credit of having made us better acquainted with this remarkable disease is due to Darier,[5] who described the histological examination and first spoke of the presence of psorospermia in two cases whose clinical aspects were given in detail by Thibault.[6] The name used in the title of this paper was given to the disease by Darier.

My investigations have on the whole corroborated Darier's observations.

The clinical history of the case here described will be reported in full by Dr. Weiss, and I shall limit myself to as brief a sketch as will be sufficient to make the case understood.

The patient is a man forty-nine years old, of medium size and average strength, who served in the war of the rebellion. In 1864, in the fourth year of his service, after the prodromal signs of pricking and sticking in the hands for several months, there appeared the first symptoms of the disease, which in the course of a year spread over the extent of surface which is at present affected. From that time the course of the disease has been very chronic, showing in some places a slow involution, in others the development of new efflorescences, with severe exacerbations during the very cold and very warm seasons of the year, at which times there has been a constant itching and burning, and the patient's sleep has been so disturbed that he has become neurasthenic. In the course of his twenty-five years of suffering the patient has made the professional acquaintance of nearly all the dermatologists of New York, and has been repeatedly the subject of microscopic examinations and of publications.

The clinical picture resembles in considerable degree the milder case of Darier-Thibault. Notwithstanding the long duration of the disease, it has not progressed to the development of little tumors with crater-formed ulcerations such as have been described.

The face and scalp are affected, and the anterior and posterior surfaces of the trunk, most markedly in the prosternal and inguinal regions; the extremities, especially the extensor surface of the left arm, the elbows, and the knees, are affected in a less marked manner.

[3] JOURNAL OF CUT. AND GENITO-UR. DIS., June, 1889. [4] Ibid., Jan., 1890.
[5] Annal. de Derm. et Syph., 1889. [6] Thèse de Paris, 1889.

FIG 1.

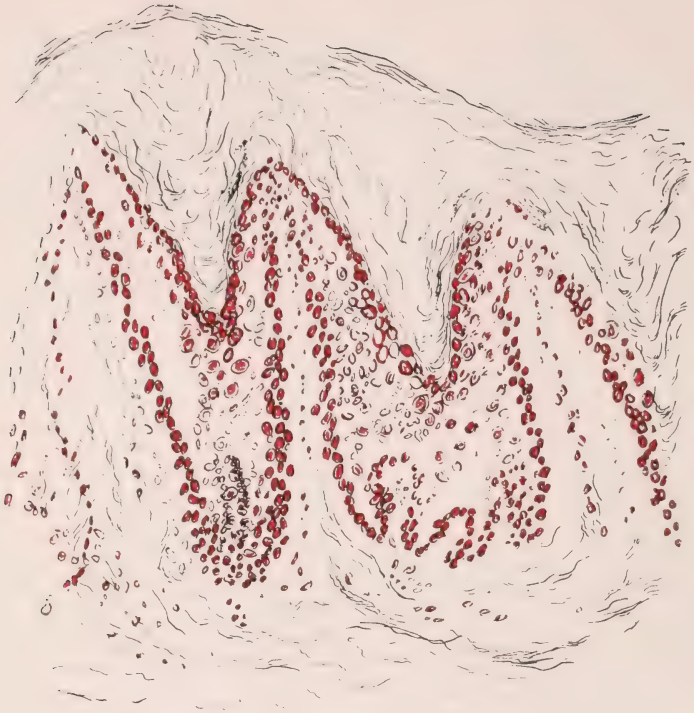

FIG. II.

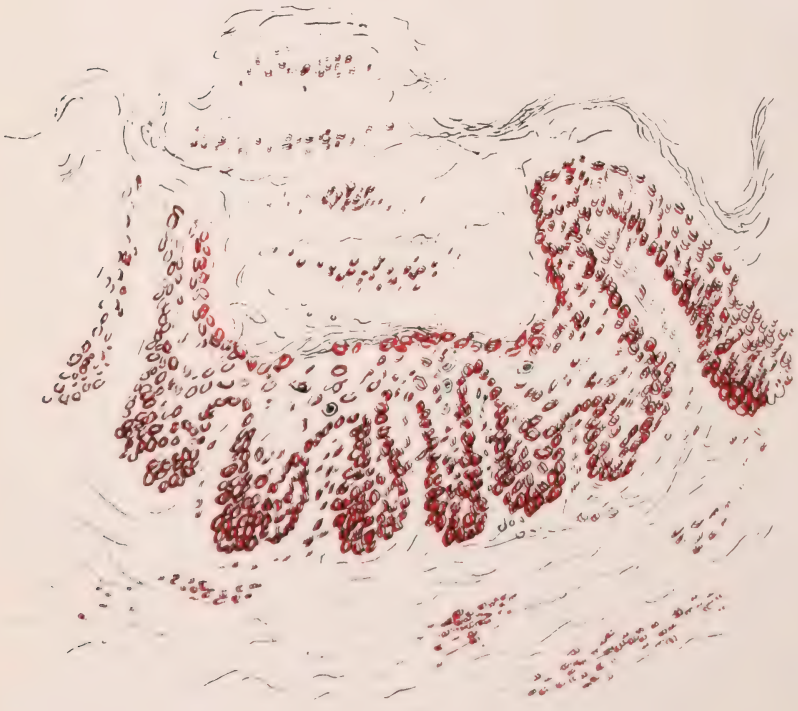

FIG III.

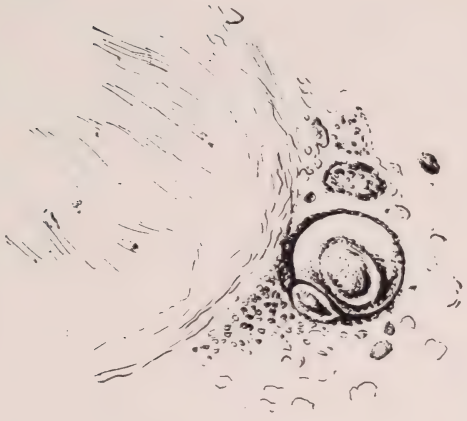

FIG. IV. (a).

FIG. IV. (b).

FIG. IV. (c).

FIG. V.

The thighs and legs show only scattered efflorescences. The nails without exception are degenerated, thickened, brittle, and split; in the groove of the nail and underneath its free edge lie masses of a brittle dirty-gray substance. The affected skin is everywhere darkly pigmented about the efflorescences, but most markedly so on the face. Efflorescences without signs of inflammation are found, especially on the non-hairy portion of the face. The face has a peculiar appearance because of its greasy shine, its pigmentation, and the large size of its pores. All the follicles are dilated to a size varying from that of a millet-seed to that of a hemp-seed, and are filled with a yellowish-brown, fatty, brittle substance, in some places translucent, which usually rises but slightly above the level of the skin. The somewhat bald scalp presents a similar appearance, except that the region about each follicle shows an inflammatory reddening, and the contents of the follicle project, like the head of a nail, several millimetres above the level of the skin, or spread as a thin, dry, greasy crust over the surrounding surface. Between the efflorescences many small irregular white atrophies of the skin are found, which are no doubt the result of previous efflorescences; these may also be seen on those parts of the body which have been long affected. The lesions on the body have a marked papillary character, consisting of small reddish-brown nodules varying from the size of a millet-seed to that of a hemp-seed, and having a small comedo-like plug, in some cases pierced by a hair. These are mostly discrete, but in some parts are near together, becoming confluent and forming small groups, or constituting, as on the left forearm, a large oval plaque healed in the centre. In the epigastric and inguinal regions are eczematous patches emitting a repulsive odor. The nipples and areolas on both sides are enlarged and prominent, but not infiltrated. The nipples themselves are shaggy, and the little elevations are covered with a thin, fatty layer which is easily scratched off, after which bleeding readily occurs. In the coating of these papillary formations, as I shall remark now, besides epithelial cells containing fat, psorospermia are found, although in less number than elsewhere. The palms and soles are normal and have never been affected.

The patient is married and is the father of several children, who, as well as the mother, show no special changes in the skin.

The affection, if closely examined, cannot be mistaken, yet in our case, as the patient states, the diagnosis of lichen has been repeatedly made. His disease is, however, so different from any of the varieties of lichen as L. ruber planus, L. ruber acuminatus, L. scrofulosorum, that it is unnecessary to discuss its differential diagnosis. Pityriasis rubra pilaris (Devergie, Besnier) has, in common with the case described of

psorospermosis follicularis, the development of comedo-like plugs, especially on the extremities; but the latter disease lacks the constant and early affection of the palms and soles found in pityriasis, and also the extensively diffused, scaly dermatitis of the face, neck, etc. The similarity of the two diseases in the plugging of the orifices of the follicles of the hairs and the sebaceous glands, which can be readily distinguished from the ordinary comedo formation, is so striking that it would not surprise me if the presence of coccidia should be demonstrated also in pityriasis rubra pilaris, which is a disease of the epidermis and its appendages. I have unfortunately had no opportunity of proving the accuracy of my supposition. (Through the kindness of Dr. Piffard I was able, at the congress, to present an excellent flash-light photograph of the sacral region in my patient, which gives us as good a representation of the condition as can be got by photography.)

If the plug of one of these follicles, especially one of those on the face, be squeezed out, the protruding mass is not white, fatty, and sausage-like, as in the case of comedones, but yellow, brittle, and spherical. Under the microscope a fresh plug, examined best in aqua ammonia, presents a striking picture. If a bit of the lower portion of a plug be examined, it is seen at once to be composed of two different elements. The first element is the epidermis cell, having for the most part a well-preserved nucleus, and containing a strongly refracting substance like small drops of fluid, which stained preparations show to be keratohyalin or eleidin. The second element is a structure which to every one who is familiar with the histology of the human tissues will appear new and foreign to the human body. It is a cell which refracts light more strongly than the human cell, and is slightly yellow, round or oval, sharply defined, and at times presents a capsule-like double contour. These cells, almost without exception, show a distinct nucleus, which consists in a round, granular mass at times eccentrically situated. The protoplasm of these cells contains some granules, and adherent to the capsule are seen the above-mentioned hyalin drops. A portion of the cells lie in small groups, apparently free, while a considerable number lie within the epithelial cells. The nucleus of the epithelial cell in this case is displaced, and the central portion of the cell is occupied by one psorospermium or rarely by two (Fig. IV., *a c*). (I will now call these structures psorospermia, and speak later of the slight uncertainty as to their nature.) There is no doubt, however, in my mind as to the intra-cellular position of many of the psorospermia. The micrometer screw and the appearance when the cells, with their psorospermia contents, roll over in a moving fluid under the microscope, proves this conclusively. When staining materials, especially picro-carmine and safranine, are allowed to flow

over the preparations, the nuclei of some of the psorospermia take up the stain, and a number of the free-lying psorospermia show a torn and wrinkled shell, which is perhaps the remains of the membrane of the epidermis cell.

The upper portion of the plug shows fewer cells and fewer intracellular psorospermia, but more free-lying psorospermia. These latter take the stain less readily than those inclosed in the cells, perhaps because of the thicker and less permeable capsule.

I have tried to discover something with certainty as to the propagation of the psorospermia (division, conjugation, formation of pseudonavicellæ or spores), but I have had no greater success than Darier. This is undeniably a great gap, which I shall attempt to fill when the opportunity offers for further study. The only point which struck me was the presence of a strongly-refracting *curved body* in the nucleus in a few of the psorospermia (Fig. IV., *b*), but I was unable to discover its significance or its relation to propagation.

The plugs from the follicles may be preserved, but do not show so clearly the above-described features. In the process of preservation the cells and psorospermia seem to loosen and become disassociated. The cell protoplasm shrinks more than the stiff-walled psorospermium.

For preservation the crushed plug may be put for twenty-four to forty-eight hours in 33% alcohol (Ranvier), and later in absolute alcohol; or it may be placed for from one-half to one hour in osmic acid or Fleming's solution, and then in alcohol; again, it may be exposed to the fumes of osmic acid. Glycerin preparations do not give a clear picture. Before examination the alcohol should, of course, be allowed to evaporate and aqua ammonia be added.

For the histological examination a piece of skin was excised from the subclavicular region and hardened in alcohol, Fleming's solution, and osmic acid, 1%. The two last-named fluids have not given me altogether the results desired, and they are not to be commended, since the horny plugs and similar structures become almost black under their use.

The histological changes are chiefly in the epidermis. (1) Affection of the ducts of the sebaceous glands and hair-follicles. The neck of the ducts is affected in so far as its structure corresponds to the normal epidermis. The affected orifices are dilated to the form of funnels open upward, and filled with yellow, glistening, irregularly-laminated, horn-like masses, containing numerous nuclei, and elevated in conical projections above the surface of the skin. Contrary to what we find in fresh preparations, sections show scarcely any trace of cells or psorospermia. In their lower portion the plugs are loose

and appear brittle, and bits often fall out of the section. The granular cells contain quantities of kerato-hyalin in two to three layers of cells, then the rete follows, consisting of irregularly-compressed cells, with a considerable amount of pigment in the basal rows. In the brittle portion the glistening yellow psorospermia can be more readily seen, lying often in groups. They are also seen singly or in small groups in the rete, but not in the stratum lucidum, as far as this latter is still preserved. The epidermis cells near the psorospermia contain a considerable quantity of kerato-hyalin. Fig. III. shows a swollen psorospermium of this sort within an epidermis cell of the layer of granular cells. The side walls and the inferior portions of the ducts, the latter especially in the hair-follicles, show a tendency to send epidermal prolongations into the cutis. When several of these prolongations are found near together, the impression is produced that there has been a new formation of papillæ. In some parts these proliferations of the epidermis attain a considerable development, and suggest beginning epithelioma. This observation, which Darier has already made, is of interest as indicating the histological relationship which exists between the epitheliomatous processes now under consideration and true epithelioma. Only in the latter does the proliferating epidermis pass the boundary of the cutis, proceed to the destruction of tissue, and finally cause metastases. The proliferation of the epidermis is in the one case benign, in the other unrestrained and therefore malignant.

The sebaceous glands and hair-follicles are normal and have not been invaded. (A single sebaceous gland had a suspicious appearance in the central portion of its acini and in its duct.) The sweat-glands were found constantly normal in their whole extent. Even the epidermis in the neighborhood of the orifices seemed to have immunity from the invasions of the psorospermia, although it possibly participated in the hypertrophic processes of the surrounding parts (Fig. I.).

(2) Affection of the rete cones. These appear broadened, lengthened, and hypertrophic, and show, at various depths in the rete, one or more psorospermia, recognizable by their optical peculiarities. As the disease progresses, the lower portion of the epidermis cones becomes broader, the epidermis cells appear compressed or atrophic and separated from each other, and secondary papillæ develop (Fig. I.).

If the process proceed still further, there will be found (3) the formations shown in Fig. II. The constituents of these formations are identical with those of the plugs in the follicle ducts. The great number of transitional forms makes me feel certain that these structures have developed in the manner described, and are independent of the ducts. These may be called *rete-cone plugs*, in contradistinction to the *follicle plugs*.

The papillary portion of the cutis shows signs of secondary reaction, in the form of fairly dense small-celled infiltrations, and considerable numbers of pigment cells. I have never found psorospermia in the cutis.

Are we justified in considering these psorospermium cells as cells of a low animal form? I believe that we are. Even if the zoölogical classification should be reserved for the zoölogist, there can be no doubt in the mind of any unprejudiced person that the organisms mentioned are neither endogenous cell formation nor the product of colloid nor of mucoid, nor of any other degeneration of the human cells. They make the impression of being foreign to the human body (*Fremdlinge*, to use a comparison of Pfeiffer's), and in the present state of our knowledge the most rational, and indeed the only possible, view to take of them is to consider them animal parasites of the cells, belonging to the class of sporozoa, a branch of protozoa. As such they are not unique. Pfeiffer[1] has collected a quantity of observations in this regard, both as to animals and man, to review which here would carry us too far from our subject.

The next question of importance which presents itself is whether these organisms stand in an etiological relation to the morbid process. A strict proof of this has not yet been given, since the psorospermia have not been cultivated and successfully inoculated in man and animals. It is different as regards the probable inference. We have, on the one hand, a particular pathological process, and on the other the constant presence of a particular micro-organism. The large series of analogous cases which modern pathology has brought to light forces us to accept, as the simplest explanation, a causative relation between the micro-organism and the disease. In the present state of our knowledge, it would be much more puzzling and confusing to suppose the constant accidental presence of non-pathogenic parasites in a disease, and we must reject this latter supposition until it has been proven.[2]

Similar conditions are found in other epitheliomatous processes in man, viz., in molluscum contagiosum (Bollinger, Neisser, Retzius, Haab and Czokor, and others), Paget's disease (Darier, Wickham), and in epithelioma (Malassez and Albarran, Thoma, Sjöborn), which speak in favor of our supposition. The fact that in a number of epitheliomatous processes of varying clinical character particular micro-organisms of the same class are found, leads us to hope that we are on

[1] "Die Protozoöen als Krankheitserreger," Jena, 1890.

[2] White's two cases (father and daughter) and the three cases reported later by C. Bock (Monatsh. f. pract. Derm., Bd. 11, No. 3) (father and son), support the idea of a parasitic affection.

the right track to the explanation and the understanding of the etiology of carcinoma. In this lies, apart from the purely dermatological interest, the general pathological importance which attaches to the microscopic conditions found in psorospermosis follicularis.

EXPLANATION OF PLATE.

FIG. I.—Slide from the skin of the subclavicular region hardened in alcohol, stained with alum carmine (ob. No. 4, oc. No. 3—Reichert). Hypertrophic rete cone not containing psorospermia, in the deeper portion of which part of a sweat-gland is to be seen. On the left side was a follicular plug, not seen in the picture; on the right side a proliferating rete cone with formation of secondary papillæ containing numerous psorospermia.

FIG. II.—Section from same region, prepared as in Fig. I. *a*. "rete-cone plug."

FIG. III.—Hæmatoxylin preparation from same region (objective 6 and oc. 8—Reichert). Granular cell containing a swollen psorospermium.

FIG. IV., *a*, *b*, *c*.—Psorospermia in cells prepared from the deeper part of a squeezed-out follicular plug in ammonia water.

a, an epidermic cell containing a psorospermium; nucleus of cell not visible.

b, the same, the nucleus of the psorospermium containing "a curved body."

c, epidermic cells with a clearly visible nucleus containing two psorospermia.

FIG. V.—Free psorospermia from the upper part of a follicular plug preserved in alcohol treated with ammonia water.

696 MADISON AVENUE.

PSOROSPERMOSIS.[1]

BY HENRY G. PIFFARD, M.D.,

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PSOROSPERMOSIS may be defined as a condition of the skin of varied lesion, but characterized by the presence of "psorosperms." During the past two years special attention has been given to the study of this condition by Darier, Wickham, and others, who declare that the so-called psorosperm is a living animal parasite, which infests the human skin as well as the bodies of some of the lower animals. The psorosperm consists of a roundish or oval cell, containing one or more nuclei, the nucleus occupying but a small portion of the cell, the plasmic portion of which is extremely transparent and structureless. These bodies are found abundantly in a certain cutaneous disease described by Darier under the name of "*Psorospermose folliculaire végétante*." They have also been found with great constancy in

[1] Read before the New York Dermatological Society, November 25th, 1890.

mammillitis maligna (Paget's disease), and are the principal pathological feature of molluscum contagiosum. In 1876 the present writer, in describing the pathological anatomy of molluscum contagiosum, wrote as follows: "We find cells of peculiar aspect which appear to be developed from the rete cells in the following manner: The rete cells increase in size, their protoplasm undergoes certain changes (degeneration of some sort), and the nucleus is pushed to the edge of the cell, where it becomes deformed and atrophied, and ultimately disappears. Following this, certain round, oval, or irregular, not very refractile formations make their appearance within the cell, looking like the condition called 'vesicular degeneration' (Cornil and Ranvier). These increase in size, and finally coalesce and occupy the entire volume of the cell from which all trace of nucleus has disappeared. They now constitute the so-called 'molluscous bodies,' and are imbedded in a connective-tissue reticulum, which appears to be a hypertrophy of that which is normally present in the rete. Reagents failed in my hands, as in those of others, to throw any light on the nature of the transformations which take place. The true pathology of the affection, therefore, still awaits solution."[2]

This solution has been reached in the minds of certain foreign investigators by the assumption that the peculiar bodies in question are animal parasites—psorosperms. This view, however, though supported by strong evidence, fails to be wholly conclusive, as it does not appear to offer an adequate explanation of some of the observed facts.

Some ten or twelve years ago a certain Max Löwenstein presented himself as a patient at my university clinic, and was shown to the class as suffering from an "anomalous" affection of the skin, which I was not prepared to diagnosticate or classify. He subsequently came under the care of several dermatologists of this city, who considered it a case of lichen ruber, and one of whom (Robinson) excised a small portion of the skin, and described the sections as pertaining to lichen ruber, or rather based his statements concerning the pathology of this disease in part on the sections in question. At that time psorosperms were unheard of, and, though present in the specimens, were overlooked. In the spring of 1890 Dr. Lustgarten brought Löwenstein to my office, still suffering from his old disease. On this occasion I excised a small portion of the affected skin. From this piece Dr. Fordyce kindly prepared some thin sections, from one of which I made the accompanying photo-micrograph (Fig. 1).

A history of Löwenstein's case, together with the photograph, were presented by Dr. Lustgarten at the International Medical Congress

[2] "Elementary Treatise on Diseases of the Skin," p. 345. New York, 1876.

which met at Berlin in 1890. The case was accepted without question as being an example of the disease described by Darier as "*Psorospermose*," etc. Quite recently a review of the specimens which were used in connection with the paper on lichen ruber revealed the presence of psorosperms.

During the early part of 1890, Dr. White, of Boston, described, under the name of keratosis follicularis, two cases, in which psoro-

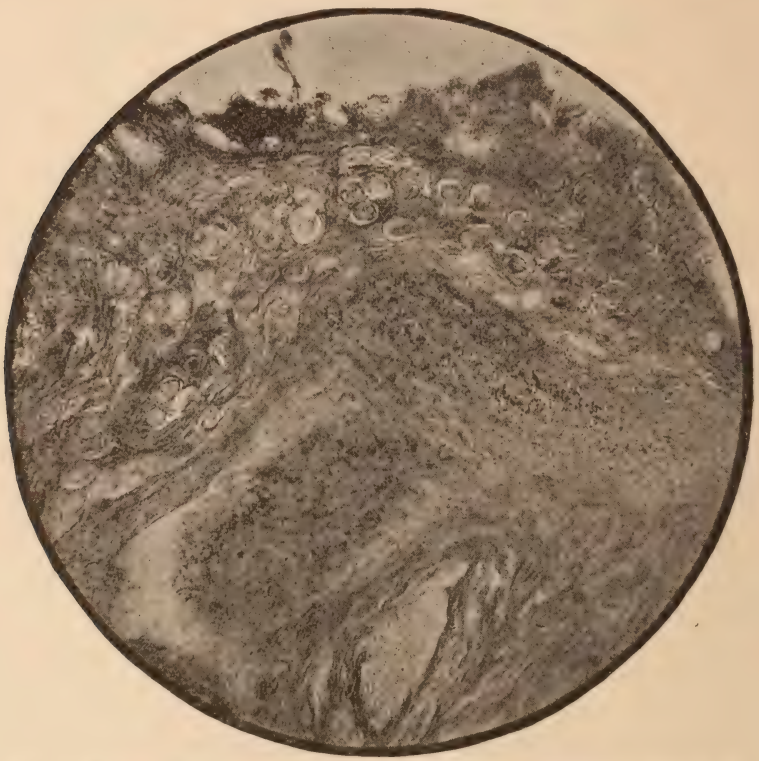

FIG. 1.—Photo-micrograph from a thin section of the skin of Löwenstein, showing the so-called "Psorosperms."

sperms were found, and claimed, on the one hand, that they were the same disease as described by Darier; and, on the other, the same as the affection described under the name *Keratosis follicularis* by Morrow. In this latter case the most careful examination of thin sections has failed to reveal the presence of psorosperms. The clinical history of the Löwenstein and the Morrow cases, and the gross appearance of the lesions, differ so widely that we are forced to the conclusion that Dr. White's claims are a little too comprehensive. His cases may have been examples of one or the other of the affections referred to,

but can hardly have been of both, unless psorospermosis (Darier) and keratosis follicularis (Morrow) are the same disease, which we are not, on the present evidence, prepared to admit.

If we accept the view that the so-called "psorosperm" is an animal parasite, we have yet to seek an adequate explanation of why it is present in such widely differing diseases as molluscum contagiosum, mammillitis maligna, lichen planus, in which it has also been found, and in Darier's psorospermosis. If we go further and accept the psorosperm as the cause of these affections, the matter becomes still more embarrassing. Comparing the diseases mentioned, we find molluscum contagiosum to be an acute, probably contagious, but trivial and readily curable affection. Mammillitis maligna is a chronic affection, which ultimately terminates in carcinoma. Lichen planus, though more or less chronic, never becomes malignant, and is usually if not always curable, while psorospermosis, as represented by the Löwenstein case, is typically chronic, and thus far has proved incurable.

To meet these difficulties, it has been suggested that perhaps there are several varieties of psorosperms, just as there are of pediculi, and that each is accountable for or to its own particular disease. We do not think, however, that even this hypothesis is sufficient to explain the widely differing clinical features of the diverse maladies in which this alien organism (?) is found. The strongest argument that has been yet presented in favor of the parasitic nature of the psorosperms is the fact that they greatly resemble certain other bodies met with in the lower animals, which are generally accepted as parasites. It must be remembered, however, that resemblance is not identity.

Per contra.—Török, at the International Dermatological Congress, held at Paris in 1889, objected most strongly, on both biological and chemical grounds, to the parasitic theory.

With the above facts and statements before him, the writer has undertaken to examine the question from still another point of view, namely, the optical behavior of the bodies with polarized light; and this line of investigation was suggested by the statement of Wickham that the psorosperms were made specially evident by the use of picric acid in the preparation of the specimens. Now, picric acid is *par excellence* the reagent that possesses the greatest affinity for horny epithelium, staining it a brilliant yellow, while the Malpighian cells are not affected by it. Applying this test to the sections from the Löwenstein case, it was found that the picric acid produced little or no effect. As there could be no reason to doubt the correctness of Wickham's observation, it forced us to the conclusion that the "psorosperms" were not always identical in chemical constitution; and that

possibly they might at one time present the features of Malpighian cells, and at another time the characters of horny epidermis—in other words, that the latter condition was found in older and the former in the earlier stages of the development of these bodies; and that the pathological process was in reality nothing more than corneous degeneration of the cells of the rete.

Polarized light, like picric acid, is pre-eminently capable of differentiating between Malpighian and corneous cells. For instance, if a

FIG. 2.—Stratified epithelial pearl—photographed with polarized light.

thin vertical section of the skin, preferably of the finger, be examined with polarized light, the stratum corneum will be brilliantly illuminated, while the stratum Malpighii will be invisible. To see if this would hold good in the case of pathological tissues, where cells of the rete type undergo corneous degeneration, the writer examined an epitheliomatous "pearl," in which the central mass consisted of stratified cells which had undergone corneous degeneration, and were surrounded by proliferated cells of the rete. Polarized light transmitted through such a body permitted the light that traversed the stratified

cells to pass the analyzer, but not the light that was intercepted by the rete cells. In other words, the horny centre of the pearl appeared brilliantly illuminated, as shown in the accompanying photo-micrograph (Fig. 2), while the rete cells were almost invisible. This clearly demonstrated that corneous cells of pathological formation behaved the same with polarized light as did the normal horny tissue. To bring this experiment to a conclusion and apply it to the question of psorospermosis, it became necessary to examine the so-called psoro-

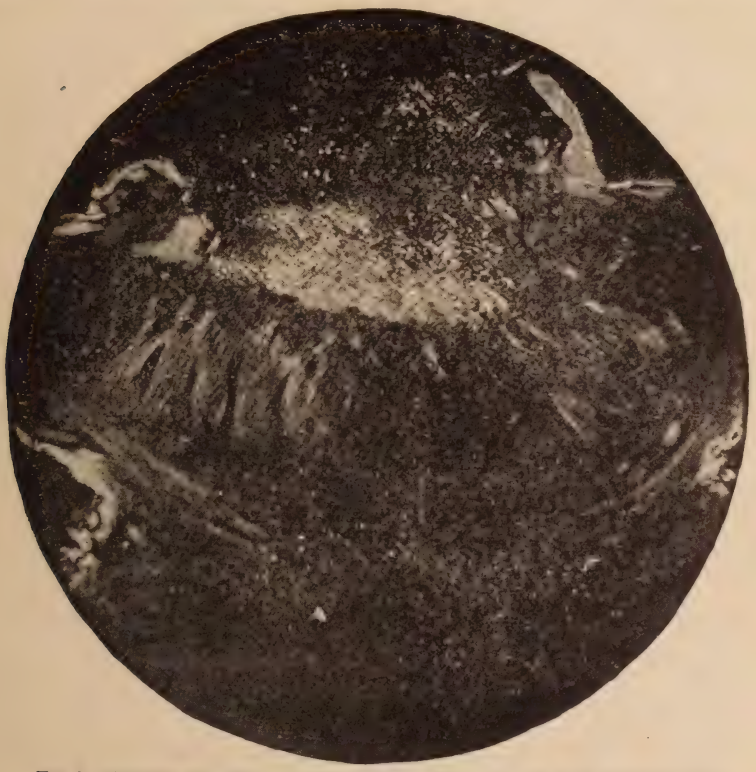

Fig. 3.—Tubercle of molluscum contagiosum—photographed with polarized light.

sperms in the same manner, but at different stages of their development. Some thin sections from a tubercle of molluscum contagiosum permitted this to be done. Submitting them to polarized light, we found that the more central, superficial, and older portion of the growth permitted the transmission of light, while deeper, peripheral, and younger portions of the growth behaved like rete cells. This is plainly shown in the accompanying photo-micrograph (Fig. 3).

From these observations I can arrive at but one conclusion, namely, that the so-called molluscous bodies, or psorosperms, are not (so far as

molluscum contagiosum is concerned) animal parasites, but are simply rete cells undergoing a species of corneous degeneration, which tends to confirm the views advanced by me some fifteen years ago.

If now we divorce molluscum contagiosum from the group of psorospermoses, we find little of importance left except Paget's and Darier's diseases. If we recollect that the prominent feature of ordinary epithelioma is a proliferation downward of the rete cells, with here and there the formation of pearls, consisting of stratified horny cells, which are perhaps caused to assume this form in consequence of pressure, we can readily imagine that Paget's disease is in reality a superficial epithelioma, *ab initio*, in which the proliferation occurs laterally instead of vertically, but with the same tendency to the degeneration and cornification of the epithelial cells.

This will leave the pathology of Darier's disease alone to be accounted for. The opportunities for the study of this affection have been thus far too limited to enable me to offer a decided opinion on the subject; but I cannot help expressing the belief that further study will result in bringing it into the pathological group of epithelial degenerations rather than into that of animal parasites.

TWO CASES OF INTRA-UTERINE ICHTHYOSIS.

By GEORGE T. ELLIOT, M.D.,

Dermatologist to the Demilt Dispensary and New York Infant Asylum; Assistant Visiting Physician to the New York Skin and Cancer Hospital, etc.

NOT until comparatively recently has the claim been made that the term ichthyosis should not be restricted entirely to those several grades of diffuse hyperkeratosis, which, beginning some months or years after birth, are not uncommonly seen and met with in adult life, but that it ought to be also extended to certain other and rarer examples, both extra and intra-uterine in development, which, though presenting quite marked clinical differences, are yet members of the same family and represent only degrees of the same pathological process. The question has been dealt with most clearly and thoroughly from its clinical, as well as from its anatomo-pathological side, by Caspary in his admirable article on ichthyosis fœtalis and also more recently by others. In Caspary's paper, the arguments and reasons demonstrative of the fact that the intra-uterine and the ordinary hereditary ichthyosis are identical processes and expressions of the same form of hyperkeratosis are presented so comprehensively, that to go

over the ground again would only entail a repetition of work already done. Consequently, the object of this article is only that of recording two cases of the intra-uterine form of the disease, which have been under my observation for some length of time and which offer some points of especial interest and peculiarity in their general course. Before giving the clinical histories of these two cases, however, I would mention and refer to some of the other examples of intra-uterine ichthyosis recorded, as little notice is given them in text-books and they are only to be found scattered here and there in journals. The process, when it has developed during uterine life, has been manifested at birth in various degrees of severity. The severest grade is the one which Lebert and Kyber termed keratoma diffusum and which has received from other observers such names as Harlequin fœtus, ichthyosis congenita, etc. To the very full list of these cases given by Caspary, one which includes both calves and human beings, there should be added one reported by Wheelock and one by Sir James Simpson, both typical examples of the process. Clinically, there is found to be a great similarity in the history and in the appearance of all of those affected beings which have been seen. They were born before full term, were puny and poorly developed, and in some portion or other presented marked deformities. They were afflicted with excessive ectropium and eclabium. The cutaneous surface itself was divided up by furrows and fissures of varying depths into hard, thick, and adherent horn plates of all shapes and sizes, which around the mouth rendered suckling impossible and which interfered likewise with all movements. Every one of the cases ended in death a few hours or days—one lived eight days—after birth.

Differing from these, in that the symptoms were less in degree, in that the children lived for months and years after birth, and in the fact that partial or complete involution of the process occurred in some instances, are those cases, also intra-uterine in development, which have been recorded by Caspary (2), Behrend (1), Seligmann (1), Munnich (2), Weisse (1), G. H. Fox (1), Frœbelius (1), and Auspitz (1). Of these, ten in all, the first six had persisted unchanged from birth to the time they were seen; Fox's patient had partially recovered; Frœbelius' and Auspitz' had gotten entirely well a few weeks after being born. Weisse does not mention whether there had been any change in his case. When seen by Caspary, his two patients, brothers, were respectively four and one and one-half years of age; Behrend's case was seventeen months of age; Seligmann's, three years; Munnich's, brother and sister, respectively four years and nine months; Weisse's, eighteen months the first time and again at age of ten years; Fox's case was five years of age; Auspitz' and Frœbelius' immediately

after birth. Clinically the cases of intra-uterine ichthyosis belonging in this category were mostly born before full term—from four to six weeks—and when seen, they were puny and poorly developed, except in the last two instances mentioned. The hands, feet and extremities were frequently flexed, the ears retracted, eclabium and ectropium present. The nails were immature or onychogryphotic. There were only a few lanugo hairs in the majority of cases, but in Fox's patient the hair was abundant during the summer. The bodily functions were normal, but in some sight and hearing were defective; in many, the absence of perspiration was noted. Weisse's boy suffered extremely from cold. The cutaneous symptoms proper varied considerably. The skin is stated to have been discolored or a dirty yellow or a brownish-black (Auspitz). It was parchment-like or covered with scales, or with small and large lamellæ of all shapes and sizes. Some of these latter were like silk paper; others resembled more nearly those seen in the ordinary ichthyosis developing after birth, or in Fox's case, there were polygonal horn plates, giving an alligator-like appearance to the skin, or there were simply a few horn plates and a universal scaliness (Frœbelius).

From the brief description given of these examples of intrauterine ichthyosis, it can be seen that as regards their clinical features, course, and termination they differ considerably from each other, but yet these differences are only those of degree and such as exist in every disease, not only of the skin, but also of other organs. The important and conclusive factors connecting them all with each other, however, are that the anatomical lesion in each is the same, though naturally in some of a higher and more marked grade than in others, and that the cutaneous symptoms are the outcome of the same pathological process resident in and affecting directly the formation of the horny epidermis; and this being the case, the variations in the intensity and degree of the clinical appearances are not of material account. The two cases, the histories of which are given here, differed also in some features from those other examples of intra-uterine ichthyosis already mentioned, but yet they belong in the same category with these. Inasmuch as they were developed in utero, they were examples of diffuse hyperkeratosis, and the clinical manifestations were never other than such as may be connected directly and alone with the horny layer of the skin. The two children were sisters, aged respectively eight and seven years at the time I saw them, and they were brought to me by their mother in October, 1886, at the Out-door Department of the New York Skin and Cancer Hospital (Dr. Bulkley's service). From the mother, a perfectly healthy Irish woman, it was learned that the father of the children was a German and that she was his second wife.

Neither one of them had ever had any trouble with their skins, nor did she know of any cutaneous disorder similar to the one presented by her children having existed in the family. The couple had had only these two, but the father had had several children by his first wife. The skins of these others were perfectly healthy, with one exception, a girl eighteen years of age, who was seen by me later and who was found to have had all her life a hyperkeratosis limited to the palmar surfaces of the fingers.

During her pregnancies, the mother did not suffer from any special or particular disturbances, and she carried both children to full term. When her first child, Alice, was born, she was covered with an excessive amount of vernix caseosa, which when removed allowed a peculiar appearance of the skin to be observed. There was not any marked or striking redness, but the entire cutaneous surface of the baby was glazed in appearance, as though painted over with a brownish varnish. Superficial fissures, running in every direction, divided this glazed coating into pieces of all sizes. From the description given they probably did not extend deeper than through the horny epidermis, for the mother repeatedly said that there were no "cuts" or deep "markings." There were no scales upon this surface and no desquamation occurred: on the contrary the coating was firmly adherent, there being only a little roughness along the edges of the plates formed by the fissuring. She also stated positively that there were no flexions of the extremities, that the movements of the child were not impeded in any way, and that it was able to suckle in a natural manner immediately after birth. The existence or absence of eclabium and ectropium could not be determined with absolute accuracy. The baby prospered and grew, though it was always and even now is very sensitive to any low temperature and subject to frequent colds, intestinal derangements, diarrhœa. The excessive formation of horny epidermis over the entire surface also persisted, no change being observed until the child had reached the age of three years. It was then noticed that the process had diminished in intensity on the face, the upper and the lower extremities. The horny lamellæ were still formed, but they became thinner, and gradually in the course of a year and a half the skin on the surface mentioned became smooth, soft, and perfectly natural in appearance. No change, except one of degree, occurred on the trunk and scalp, and it was these surfaces which were affected at the time I saw the patient.

On examination she was found to be well grown for her age, perfectly developed and formed, without a trace of malformation of any portion of the body. She was bright and intelligent. Her general functions were in a natural state, but she never perspired, except on

the upper lip and a little on the extremities. There was also a slight degree of anæmia present.

The skin of the face (Diagram I.) from the margin of the hair on the forehead to the middle of the neck anteriorly, of the ears, of the back of the neck, and of the upper extremities, from and including the shoulders to the tips of the fingers, and of both scapulæ, was perfectly normal in appearance, smooth and pliant. The lower extremities also, from a line beginning at the pubes and running along Poupart's ligaments and the crests of the ilia to the body of the first sacral vertebra, were in their entirety absolutely without blemish. There were no cicatrices at the angles of the mouth or eyes suggestive of deep fissuring which might have existed at some previous time. The lanugo hairs were well developed on the arms and legs; there were no scales anywhere and not even a trace of an ordinary keratosis pilaris.

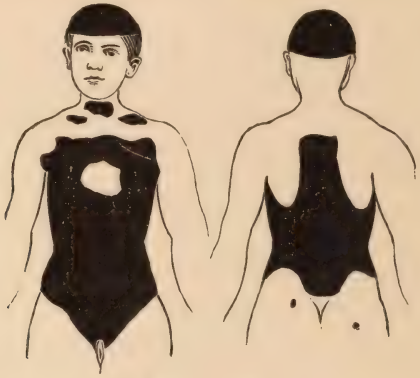

FIG. 1.—CASE I.

The affected surfaces were the scalp and trunk. The former was covered, as with a closely-fitting cap, by a thick uniform mass of horny epidermis having a sightly greasy feel from the admixture of sebum. There was not any desquamation, but the coating, which varied in color from a brownish-yellow to a dark brown, could be stripped off in large pieces without difficulty. The underlying surface appeared natural, being neither reddened nor moist. The hair, which was abundant, glossy, and in every particular healthy, grew up and penetrated through the epidermic mass. There were also irregularly-shaped patches on the neck anteriorly and above each clavicle, which were covered with yellowish, shiny, and adherent scales about the size of a small finger-nail. The centres of each were depressed and only their edges were slightly loosened and free. On the trunk, the horny accumulation began on a level with the third dorsal vertebra, filling up the interscapular space and extending uniformly over the

back to the first sacral vertebra. Leaving the skin over both scapulæ free, it curved around their inferior borders to pass into the axillæ, which were severely affected, and thence extended over the entire chest, except a small portion of the infraclavicular region and an irregular-shaped space over the lower half of the sternum and inner mammary region. The epidermic masses covered also the entire abdomen and flanks in a uniform manner, the boundary below being quite sharply defined and constituted by the pubis, Poupart's ligament, and the crest of the ilia as far as the sacrum.

This horny coat varied in thickness from a line to three and four lines, and in places even more. It was thinnest on the back, more pronounced on the abdomen, but thickest in the axillæ, where it existed in the form of small, hard, horny excrescences and polygonal plates, which were detachable with only great difficulty. Its color varied from a light yellow to a dirty gray, a brown and brown-black. The diffuse coating was everywhere divided up into plates and lamellæ of all sizes by fissures transverse to and parallel with the longitudinal axis of the body. These fissures were superficial, not penetrating the cutis, and from their direction on the various portions gave the impression of having been produced by the movements of the body. On the back the transverse fissures were most marked, and the longest diameters of the plates ran in the same direction, while on the abdomen the longitudinal ones predominated. The lamellæ and plates on the back were not more than one inch by one-half inch in size, and were more frequently smaller; on the abdomen, they were in many instances two to three and even more inches long and one or one and a half inches broad. They were also very adherent, but could be stripped off with some force, and on their under surface there could then be seen a number of little horny prolongations. The surface uncovered had a natural appearance, was not reddened or, as far as could be judged, changed macroscopically, except that it appeared a little coarse. There was no desquamation or scaling apparent upon the surface of this coating, it being quite smooth and only showing decided roughness at the fissured edges of the plates and lamellæ. Unfortunately no sections of the skin could be obtained for examination under the microscope, only pieces of the lamellæ. Preparations made from those removed from the body were composed entirely of horny epidermis cells, while from the scalp there was, in addition to these, a more or less great amount of fatty matter.

The patient was prescribed treatment, but as the mother and family were convinced that internal medication was the only one which could benefit the child, the local care and use of the local applications for the disease were neglected or only carried out once in a

while. In consequence, no result or change in the condition of the pathological features of the case was obtained or observed. The child was seen by me at irregular intervals for a length of time, and on two occasions presented most interesting manifestations upon the portions of the skin already mentioned as healthy in every way. On April 25th, 1887, she returned and it was stated that on April 1st she had been taken sick with measles. It had run a mild course, the eruption lasting only a few days and the child being perfectly well again by the 15th. The skin of the trunk and scalp was found by me to be in *statu quo ante*, but that of the extremities and face, previously perfectly normal, was covered with a wrinkled and fissured epidermis, which in appearance was typical of an ichthyosis as usually met with in adult life. There were scales and lamellæ of all sizes on the face, but on the extremities these were arranged in such a manner that the

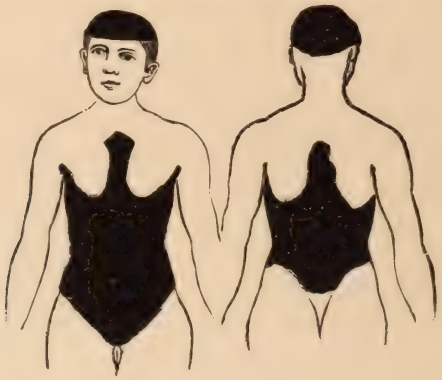

FIG. 2.—CASE II.

resemblance of the surface to a fish skin was most striking. Under the use of a salicylic-acid ointment these symptoms disappeared completely in a week, the skin regaining its natural appearance. October 24th, 1887, the patient was again seen, after she had had a severe cold accompanied by fever and a sore throat, which had lasted for a few days and was still present. This time the typical appearances of an ichthyosis had developed on all those portions of the neck previously mentioned as free from the disease and apparently normal. The symptoms disappeared completely a few days after the subsidence of the general systemic disturbance. Since then, the child has been seen occasionally, but no change has been observed in the cutaneous disease.

The younger sister, Wilhelmina (Diagram II.), seven years of age, gave the same general antecedent history. She was born at full term and universally affected with the disease. Its disappearance began at

about the same age as in her sister, and from the same portions of the body. She grew up in a normal manner and when I saw her was a stout, perfectly formed and built child, healthy in every way. The skin of the face and of the extremities was absolutely normal, her complexion a beautiful one. The epidermic accumulation occupied nearly the same localities as on her sister, but it was much less in degree. Except around the umbilicus and in the axillæ, the lamellæ and horny plates were considerably thinner, but the appearances were on the whole the same as have been mentioned in the case of Alice. On the thorax and in the lumbar region, however, there were patches, at first sight apparently normal, but intersected in every direction by light brown lines, producing a most peculiar checkered aspect. The lines were thought to be due to slight pigmentation, but when they were more carefully examined it was seen that they were produced by a slight loosening and fissuring of the horny epidermis, the transparency and wrinkling of which caused the brownish hue.

The course of the process was the same as has been mentioned for Case I., and when last seen there had not been any change in the disease. The little patient had also had measles at the same time that her sister had. It had run a mild course, and though she was carefully examined on the same day that Alice was, there was no evidence found that the healthy portions of the skin were affected by the measles in the same way as in the case of her sister. It was said that there had been very little desquamation and when I saw her, the skin was perfectly normal, except on those portions covered by the epidermic hypertrophy.

The cutaneous affection from which these two children suffered could not be regarded as any other form of disease except ichthyosis. The only symptom manifested during its entire existence was the condition of epidermic hypertrophy, which had come to be limited in so peculiar a manner to the regions mentioned, and this being the case, they have to be placed in the family of hyperkeratoses, or more particularly in the subdivision of that family represented by the ichthyoses or hyperkeratoses occurring in a diffuse manner, as distinguished from those which are localized—clavus, cornu cutaneum, etc. My two cases being affected with the disease at birth, it must have been of intra-uterine development, and consequently they belong among those enumerated as having a similar orgin—that is, were examples of intra-uterine or fœtal ichthyosis. Still they represent only medium or slight grades of this latter, inasmuch as both children had not only grown up, but were fully developed mentally and physically in proportion to their age, were perfectly formed and well nourished, and in no particular showed any of those pitiable features of deformity or of

retarded development reported in the majority of the cases in literature, even among those who survived for some years after birth.

The most peculiar feature in these two cases is the complete spontaneous involution of the disease and its absolute disappearance from certain portions of the body. In both children, the involution began at about the same age—three and one-half years—and occurred upon the face and the extremities. There is no possible explanation to be given for the choice of these surfaces, and it seems strange that the skin of the arms and legs should have become perfectly normal, as far as could be judged, inasmuch as they are the favorite seat of ichthyosis in general, though especially of the ordinary form met within adult life. During the several years that the children were under observation, these surfaces remained unchanged except in the eldest, Alice, who for a short time after an attack of measles and also subsequently when suffering from a severe cold and sore throat, developed upon the previously unaffected portion of the body a typical ichthyosis nitida. Similar changes did not occur in the younger sister, Wilhelmina, under the same circumstances, and though the natural inference would be that the scaliness observed in Alice was the desquamation which takes place after measles, yet precisely similar but more localized symptoms were developed on another occasion, when the patient had been suffering from a trouble unaccompanied by any epidermic change. Besides, at neither time was there any true scaling, nor after the measles was the desquamation the branny one of that disease, but there was the distinctly tesselated appearance of ichthyosis, the scales being adherent in their centres and only slightly loosened at their edges. The entire appearances strongly suggested the idea that under the influence of morbid states affecting more or less the general system, the epidermis, which objectively was normal, tended to revert to its original condition, but that tendency being only a slight one, and the cause or causes which evoked it transitory, only a slight degree of the original process was reproduced.

Another peculiarity of these cases is seen in the entirely natural condition of the hair on the scalp. It was abundant, glossy, and apparently normal in every particular, notwithstanding the presence of the process over the entire scalp. In the cases of intra-uterine ichthyosis recorded, the hair has been for the most part scanty and poorly nourished and even entirely absent. In none of them has it been in any way normal. (Nothing is said in regard to the condition in the cases of Auspitz and of Frœbelius, cases which recovered entirely.) That the nails were not affected was probably due to the fact that the extremities in their entirety had become perfectly free from the disease. At any rate, the nails on fingers and toes were in every way absolutely normal.

When taken in their entirety, these two cases may certainly be said to represent most unique and peculiar examples of intra-uterine ichthyosis, and as such have been considered worthy of being recorded.

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No. 7 WEST 31ST STREET.

TO RENDER THE INTRODUCTION OF LITHOLAPAXY TUBES LESS DIFFICULT.

BY WILLIAM K. OTIS, M.D.

SINCE the establishment of litholapaxy, the difficulty attending the easy introduction of instruments, especially in cases complicated by the presence of an enlarged prostate, has been one of the important minor problems confronting the operator, the obviation of which has commanded a certain amount of attention from both surgeons and instrument makers.

It is especially desirable in this operation that even trivial lesions of mucous membrane be avoided, as they not only open the way to possible septic infection, but also complicate the operation by the presence of blood in the evacuator. In by far the larger number of cases in which lacerations of the mucous membrane occur, the injury is produced not in the bladder itself, but in the deep urethra, caused by the passage of instruments even in the hands of a skilful operator.

This is particularly the case with the tubes, the eye of which forms an obstacle to easy introduction by no means overcome by the obturators now in use. The ordinary hard-rubber obturator not only leaves a raised edge of metal above its surface, but if close-fitting is apt to be difficult of withdrawal; while the soft-rubber obturator, though free from these objections, is too short-lived to be practical.

An obturator which I have devised is simple, durable, close-fitting, and easy of withdrawal. It consists of a hard-rubber plug which entirely fills the eye of the tube, having a shoulder which obliterates the

edge of metal at the proximal end of the eye, and is kept in place by a small steel spring, strong enough to hold the plug in position during the introduction of the tube, but which readily yields when the obturator is withdrawn.

The practical working of this device, which has now been in use for over a year, is admirable, and it may be adapted to both straight and curved tubes.

Another form of tube which is sometimes of service as being easy of introduction is illustrated below. In this instrument the tube itself is perfectly straight, but has a false tip at the distal extremity which gives it the curve of the ordinary sound, thus having the advantages of the curved instrument for introduction at the same time the current is direct, rendering it especially adapted to the removal of foreign bodies other than stone. In this tube the solid rubber obturator fits perfectly, but in using it it is necessary to turn the eye upward, otherwise the vesical mucous membrane, acting as a valve, will prevent the exit of fragments.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

202D REGULAR MEETING.

DR. E. B. BRONSON, *President, in the Chair.*

Recurrent Macular Syphilide Ten Months After Infection.—DR. BULKLEY presented a patient, aged 24 years, with this affection, who gave the following history:

Had venereal sores three years ago accompanied with buboes, which have left scars in the groins. Had no eruption then, but lost his hair

badly (?). Then he had only treatment for gonorrhœa and local treatment for the sores: took cubebs and copaiba. In January, 1890, he had a sore on penis, and in February, 1890, he came under observation. He then had mucous patches on the lips and tongue, with a general maculo-papular eruption, and in June he had falling of the hair. On August 9th he came with a characteristic papular eruption on both palms, some slight remains of which are still present. On August 30th he had mucous patches on the prepuce. On October 18th all lesions had disappeared, and he was not seen again until November 15th, when he returned with a diffused macular eruption, which had existed for two weeks and which still persisted on November 20th, it having now developed more abundantly under a mixture of rhubarb and soda given on November 11th.

The trunk is now covered with a macular eruption closely resembling the macular syphilide, with scattered macules on the extremities. There is some enlargement of the inguinal glands.

DR. KEYES believed the diagnosis to be correct. The history appeared to be perfectly reliable. He had seen a relapsing roseola as late as the second year after infection.

DR. ALLEN had seen relapsing roseolas as late as this one, but none in which the color of the lesions was as bright red.

DR. KLOTZ believed the eruption to be a modified papular syphilide, the development of which was checked by the effect of the remedies. The eruption was not entirely macular, as in some places a distinct infiltration could be seen.

DR. BRONSON desired to know if the patient had not been troubled with excessive sweating, and also if Dr. Bulkley had considered the probability of a parasitic origin of the affection.

DR. BULKLEY replied that the patient had perspired freely, but that he had not considered the possibility of a parasitic affection.

DR. BRONSON said that the color and irregular circinate outline of some of the lesions suggested a parasitic affection.

DR. TAYLOR said that it was not at all unusual to see relapses of the roseola as late as the eighteenth month after infection. The tendency of the late roseolas was to localize themselves and to occur in circinate forms.

It was somewhat difficult to diagnosticate such roseolas from seborrhœal affection or from the tineas. Ephemeral roseolas not infrequently occurred during the course of the disease in those who had had early lesions of a severe type and in those who had been given iodide of potassium in the early stages.

DR. BULKLEY in closing said that the suggestion of Dr. Klotz, that the eruption was a modified papular syphilide, was a good one. The occurrence of ringed erythematous eruption, looking like ringworm, we frequently see as late as two or three years after infection, but a generalized eruption, like this one, is certainly rare.

A Case for Diagnosis.—Presented by DR. CUTLER. Chas. S., aged 33 years. Has always been in good general health. Denies any specific history. Never had any eruption upon the skin until three years ago, when he noticed on the front part of the left leg, between the knee and ankle, a number of little dark spots under the skin. As there was no pain or itching accompanying the eruption, he did not pay much attention to it for some time, until he noticed that these spots still remained while new ones were making their

appearance, gradually increasing the size of the patch. From that time until the present the eruption has been gradually spreading, until now it almost covers the leg below the knee. A year ago the same eruption appeared on the other leg and has been gradually extending until it almost covers that leg also. The eruption, the patient states, has always been of the same kind as is now present on the legs. There has never been any severe itching or pain, most of the time none at all, nor has there been moisture present at any time, but there has been a little fine scaling. He has never had any eruption on the rest of his body.

On examination the lesions are found to consist of a mixture of pigmentary stains and purpuric spots about the size of pin-heads. These are mostly discrete and quite scattered about the periphery of the affected regions, but in the centre of the patch they have run together, producing an almost uniform discoloration of the skin, which looks very much at first glance like an old eczema. The skin is not much thickened, but is dry and feels like parchment. It is covered with fine scales. The color of these spots varies from a dark red to a deep yellow.

DR. KLOTZ said that some time ago the case would have been classed as an eczema, but at present we were more cautious in pronouncing such a diagnosis. He believed, however, that a slow inflammatory process was present, complicated by some irregularity of circulation or of the blood-vessels. He had observed similar conditions of the skin not so very rarely surrounding scars from superficial ulcers of the leg, and he believed that on close inspection the skin would be found more or less sclerotic and atrophic.

DR. SHERWELL said there were eczematous manifestations, but that he regarded the primary trouble as an idiopathic purpura.

DR. BULKLEY regarded the trouble as due to dilatation of the cutaneous capillaries forming minute varices, which might simulate a purpura.

DR. CUTLER said that by daylight the eczematous element was almost entirely absent. There was no history of eczema; no thickening of the skin; no itching; the scaliness was only slight. Where the lesions coalesced, forming patches, the appearance was like that of the pigmentation resulting from a chronic eczema, but where they remained discrete they were seen to be purpuric and not simply vascular dilatations. On pressure the spots do not disappear at all, but after they have existed for a certain length of time the coloring matter of the blood was changed so as to leave a deep pigmentation, which was permanent.

DR. BRONSON spoke of a pigmentary disease of the legs occurring in Ireland, more particularly in old women who were accustomed to sit over peat-fires, and known as "trouts," and also of the affection in Italy, called by Sauvager "*Ephelis ab igne*," said to be produced by warming the feet and legs over *scaldini*.

DR. KEYES recollected seeing an old woman in the St. Louis Hospital, in Paris, who had deep pigmentation of the legs without any particular eruption. It was explained as follows:

The market-women come in from the country very early in the morning, and while waiting for customers place a charcoal brazier beneath their dress to warm their feet. This, if long continued, produces deep pigmentation of the legs.

Molluscum Contagiosum.—DR. ALLEN presented a child with a molluscum tumor on the inner surface of the arm and two smaller tumors on the body.

The peculiarity of the case was the large size and color of the tumor, which instead of presenting a waxy look was bright red, and the mother maintained that the color had been the same since it was first noticed.

DR. SHERWELL thought it was molluscum contagiosum, and would like to ask in regard to the possibility of the tumors changing sometimes into molluscum fibrosum, the upper layer of the corium being apparently involved.

DR. PIFFARD thought there would be grave objections to the theory of the conversion of the one disease into the other, as molluscum contagiosum was an epithelial disease, while the other was a disease of connective tissue.

Acne Varioliformis on the Extremities.[1]—DR. BRONSON presented a young man with the affection, showing the disease in its various phases of evolution and involution. A few recent lesions were seen, but the majority of the spots of infiltration had healed, leaving depressed pigmented scars.

DR. MORROW had no better diagnosis to offer than that proposed by Dr. Bronson, as the lesions undoubtedly presented the characteristic appearances found in that disease. The location was certainly unique. He doubted the propriety of applying the term acne to lesions occurring upon the hands, because in the most aggravated cases of that disease we do not find it occupying that situation.

DR. FOX spoke of the similarity of this case to the one shown by himself at a meeting of the society some time ago, in which a diagnosis of acne cachecticorum was made. This patient had numerous pustules over his arms and back, many of them round and superficial, similar to the lesions in Dr. Bronson's case, and scattered among them were numerous comedones. He objected to using the term acne for an affection of the extremities which did not involve primarily the sebaceous glands.

DR. JACKSON said that the case more nearly resembled the pustular scrofulader of Duhring. He had shown a case similar to this one a few years ago at a meeting of this society. It recovered under the use of cod-liver oil and iron, while it had proved rebellious to all local remedies without these general ones.

DR. ALLEN said that his understanding of the disease—acne varioliformis—would not permit his making this diagnosis in the case presented. Acne varioliformis in his experience occurred mostly among immigrants. The lesions were situated on the face, especially the bearded portions, about the hairy margin of the scalp, and sometimes upon the nose, but never, so far as he had observed, upon the extremities. He would look upon the case under consideration rather as an acne-like dermatitis in a strumous individual.

DR. PIFFARD thought the name acne varioliformis an unfortunate one, as it had been applied to two distinct affections.

DR. BULKLEY did not like the name acne varioliformis. He had described this disease under the name of acne atrophica, which is probably a better name than acne varioliformis, inasmuch as there are acneiform lesions followed by atrophy and permanent scars. He had seen several cases presenting lesions similar to those here observed, and had exhibited one of them before the society about ten years ago. In this instance the lesions were very numerous on the hands, some occurring also on their palmar surface. He had seen improvement result in his cases under the use of drugs directed against the strumous condition. No local remedies had been used.

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[1] The case will be reported in a subsequent number of this journal.

DR. TAYLOR said he had seen in late syphilis even to nine years after infection, in untreated cases, in those to whom iodide of potassium had been given in immoderate doses, or in persons from chronic visceral diseases from drink or otherwise, an eruption similar to the one presented by Dr. Bronson. It had been seen by him upon the face, forehead, nose, neck, and body. On the trunk it occurred much more superficially than upon the face, chiefly on the shoulders, arms, buttocks, etc.

As the lesion begins a little red spot is noticed about a follicular opening, which soon increases to a papule: after a time necrotic changes take place and the redness of the infiltration gives way to a brownish-green crust, which is very adherent but which may be pulled out like a plug, not occupying, however, the entire superficies of the lesion. A scar very similar to that of small-pox results. Upon the alæ nasi very marked deformity may result.

DR. FORDYCE thought the case presented a typical one of acne varioliformis, but considered its connection with the hair follicles or sebaceous glands as questionable. He looked upon it as a localized infiltration of the skin produced by some infection. The tendency of the infiltration to undergo rapid necrosis and absorption were the clinical features which separated it from allied diseases.

DR. BRONSON said the disease had recently been described by Boeck and afterward by Pick in the *Archiv für Dermatologie und Syphilis*. In Boeck's case the lesions became gangrenous and occurred not only on the face, but also upon the trunk. He recognized the objections that had been made to the term, but maintained that in his case the affection was identical in nature with the disease that had been described under that name. He looked upon the disease as parasitic from the tendency of the lesions to group themselves and from the curative results obtained from anti-parasitic remedies. In the case presented a germicide lotion containing the bichloride with boracic acid had exerted a decidedly beneficial effect. He was disposed to associate this disease with a group of diseases which had been especially studied in France by Quinquand, Lailler, Brocq, and others under the name "acné décalvante." They were characterized by pustular inflammation of the hair follicles of the scalp, the lesions occurring in groups, spreading at the periphery, and leaving permanent alopecia with scar tissue. This affection had been pronounced by Quinquand to be parasitic.

DR. FOX said that in all cases in which the sebaceous glands are supposed to be affected the early lesion produces a superficial elevation of the skin. In a previous examination of Dr. Bronson's case he had noted that nearly all of the lesions had begun as deep-seated shotty papules below the situation of the sebaceous glands. These gradually became red upon the surface of the skin and then formed hemispherical pustules, the central portion of which dried into a hard depressed crust and finally left a pitted cicatrix.

DR. ELLIOT had noted the points in evolution of the lesions mentioned by DR. FOX. In his opinion the changes characterizing acne varioliformis did not occur in the glands or hair follicles. For that reason it could not be associated with the acné décalvante of Lailler, a disease unquestionably follicular in situation.

Selections.

Concerning the Condition of Sexual Susceptibility and its Deficiency (Anaphrodisia) in Coitus. PROF. V. KRAFFT-EBING. (*Internat. Centralbl. f. d. Physiol. u. Path. d. Harn- und Sexual-Organe*, Band ii., Heft 3 u. 4.)

The satisfactory termination of the sexual act depends upon the intensity of the orgasm.

In man this begins with the continuous entrance of semen from the seminal vesicles and ejaculatory ducts into the membranous urethra. It increases then momentarily and culminates at the height of ejaculation, to rapidly recede immediately thereafter.

In woman it is developed more slowly and continues longer than with the male. It is produced by an intense reflex excitation in the lumbar cord, an analogous centre to the ejaculatory centre in man, which produces a muscular contraction of the vessels of the entire genital tube. The question to be answered relates to the conditions pertaining to the occurrence of sexual pleasure. It is to be understood that this seems due to a psychical action of the centres of consciousness—*i.e.*, the cerebral cortex.

And it cannot be doubted that muscular contractions, excited in a reflex manner, take place at the height of the sexual act.

These may be produced by peripheral acts or by phantasy. The decisive factor is the cerebral cortical process. The possibility of occurrence and the intensity of this pleasure is evidently dependent upon the degree and manner in which the cortical centre may be thrown into action.

There is no doubt that the cortical centre itself is affected by the state of the genitive organs, ovaries, and testicles.

It is a well-known fact that at the time of distention of the seminal vesicles and at the time of the ripening of an ovule the cortical centre is particularly susceptible; and, *vice versa*, the reversal of this condition results in diminished sexual desire.

There are women with feebly-susceptible cortical centres in whom coitus at the pre or post-menstrual epoch only is accompanied with pleasure.

Inasmuch as the susceptibility of the cortical centre is the essential factor, we can see how psychical conditions have great influence upon the feelings of pleasure. Most notable are the cases in which the feeling of pleasure is excited, not by a normal, but by a perverse action of the psycho-sexual centre, such as mutual masturbation, pederasty, etc.

There is a difference between male and female dynamic as regards orgasm and the feeling of pleasure. Experience teaches that the ejaculatory centre in the female is much less susceptible than in the male. This is the result of education, which turns the female mind from the sexual domain and enjoins strict virtue both in thought and action. Besides, this function in the female is more gradually developed by sexual intercourse.

Moreover, while the permanent absence of this feeling of pleasure in man is of rare occurrence, there are numerous women in whom the ejaculatory centre never goes into full activity, so that they never experience pleasure in

coitus. Whether this tardiness or absence of the feeling of pleasure in women is to be ascribed to late or imperfect development in the spinal centre or to an inhibitory influence from the cortical centre, is a question which must be left unanswered. In favor of the latter view may be cited those women who permit coitus, although dreading pregnancy, and believing that this feeling of pleasure favors conception, they are able to suppress it by exercise of the will. These facts also explain how prostitutes are able to have connection *ad infinitum* without over-excitation and over-exhaustion of the nervous system.

There are cases which exist where the inactivity of the spinal centre is not due to prohibitory influence from the cortical centre, but to anomalies of the spinal centre itself : for instance, women with great but unsatisfied desire.

It has been assumed, and with justice, that the peripheral irritation which brings about ejaculation and the feeling of pleasure in coitus is produced by friction and excitation of the corpuscles of Krause, which form the termination of the sensitive nerves over the glans penis and clitoridis. That insufficient irritation of these pudendal nerves in women can act as a barrier to the ejaculation reflex must be admitted.

The causes, then, of the absence of pleasurable feeling in the female are, first, of a subjective nature due to insufficient friction of the glans clitoridis, owing to abnormalities or to anæsthesia of the genitals. In the second place, as regards faults of the male, or objective causes for absence of pleasure on the part of the female, are to be mentioned ejaculatio præcox, coitus reservatus, condomatus. When we add to this great insusceptibility of the spinal centre, whether due to imperfect exercise or psychic prohibitory influence, and finally insensibility of the cortical centres, then we exhaust all the possibilities which have to do with the lack of pleasurable feeling in the female.

As regards the same deficiency in men, the conditions are more complicated.

1. Inactivity of the cortical centre (anæsthesia). This is congenital in rare cases. More frequently acquired by neuroses, neurasthenia, hysteria, or hypochondriasis. As a rule, desire is wanting and occasional pollutions are the only intimations. The psychical factor in these cases is demonstrated by the dreams which accompany the pollutions, but which do not represent females in lascivious positions, but perverse images.

2. Inactivity of the ejaculatory centres. It is scarcely possible that this can be the result of an inhibitory influence from the cerebral centre, for otherwise the erective centre would be interfered with. Not rarely this inactivity is the result of disease of the lumbar cord and organic disease of the cord or a functional disorder (exhaustion). In such a case the erective centre would always be involved.

It is noteworthy that in these cases libido may be great and at the same time pleasure be wanting (certain cases of neurasthenia in the early stages). Besides this, aspermatism may be the cause, and finally disease of the peripheral genital apparatus (anæsthesia of the external genitals, anæsthesia of the urethra, paralysis of the expulsive muscles of the semen).

In cases where pain instead of pleasure occurs at the height of the sexual act, there are always anatomical changes in the prostatic or membranous urethra, in the shape of gonorrhœa or stricture.

While to man the feeling of pleasure is connected with the existence and ejaculation of semen, and hence disappears sometimes after castration, at

any rate earlier than libido, in females, owing to the above-stated reasons, this feeling of pleasure is still possible notwithstanding castration—at any rate disappears later than libido.

It seems to be dependent upon the maintenance of peripheral irritability of the clitoris.

If the hyperæmia of the generative tract which accompanies coitus does not recede with the culmination of the act, various functional or organic changes may arise. These are only absent when the libido and orgasm are entirely wanting, as in prostitution, frigidity, and repugnant coitus.

The functional disturbances consist in symptoms of hyperæmia of the pelvic organs, probably also of the lumbar portion of the cord (dull pains in the sacrum, feeling of weight in the pelvis and lower extremities and exhaustion), and frequently persist for a few hours. If the unsatisfactory intercourse (impotence of the consort with great libido and with a spinal centre difficult of excitation) takes place frequently, female diseases are produced—chronic metritis, endometritis, prolapse, etc., attended with symptoms of dysmenorrhœa, leucorrhœa, constipation, or, still more frequently, affections of the nerves in the form of neurasthenia sexualis. If the nerve and genital disorders are simultaneously present, we are apt to ascribe the latter as the cause of the former, although both are not infrequently dependent upon the common cause just mentioned. Unsatisfactory coitus in the female has not only a somatic, but also a psychical action on the body, and especially if marked libido is present which is not satisfied by the act. It is shown by hysteria.

In a general way anaphrodisia will only lead to neurasthenia, and only in cases where the above-mentioned psychical factors are concerned will the nervous system be affected in the form of a hysteria.

If there is, together with this anaphrodisia, a forced hyperæsthesia sexualis, other dangers may arise. In case of ungratified sexual intercourse with the male, masturbation. In case of unsympathetic intercourse, psychical onanism or marital unfaithfulness.

Here the author gives several cases cited from Dr. Laker's practice illustrating the danger of onanism arising from ungratified coitus. In view of these, the author dissents from Laker and states that it is still an open question whether the person affected failed to experience an orgasm because of original difficulty of exciting their spinal ejaculatory centre or whether masturbation, acting injuriously upon the psycho-sexual centre, should be held responsible. In favor of the latter view he cites a case from Troggler, in which repression of masturbation by appropriate treatment resulted in partial restoration of normal functions.

To further illustrate the injurious influence of masturbation to the female upon the occurrence of voluptuous sensations, the author cites three cases from the practice of Dr. Loiman, whose conclusions he approves, differing from those of Laker, in that he concludes that onanism effects a functional change upon the psycho-sexual life by reason of its fatal reaction upon marital relations. The same experiences as regards the loss of voluptuous feeling were made by Krafft-Ebing in a number of male onanists. In all of these cases there was neurasthenia sexualis. Frequently the desire was very active, and the pleasure which was wanting during coitus was present during masturbation. The cause of this absence of voluptuous feeling in these cases could evidently be only attributed to psycho-sexual anomalies in the sexual

centre of the cerebral cortex. It is evident that these patients are only relieved of their trouble with difficulty. Contrary to these cases of anaphrodisia arising from masturbation, rare instances have been observed which favor the possibility of a peripheral origin of the anaphrodisia. Under this head Guttzeit observes that females lost their sexual gratification in consequence of a rupture of the perineum, although it was, previous to rupture, fully developed. This was due to insufficient friction, by consequence of tearing of the constrictor cunni; hence the sensitiveness of the most irritable portion of the vulva was considerably reduced.

In the male, also, the absence of voluptuous feelings in the female during coitus is not without significant effects. F. TILDEN BROWN.

Removal of an Eight-ounce Vesical Calculus by the Supra-pubic Route. HENRY C. SIMES. (*Annals of Surgery*, Vol. XII., No. 2, Aug., 1890.)

The patient, Mr. L., 38 years, had suffered for four or five years with bladder trouble, under which his health had of late rapidly broken down. The patient's condition and the size of the stone induced the operator to perform lateral lithotomy. On reaching the cavity, digital examination revealed a much larger stone than was expected, and convinced the operator of the futility of attempting to extract it entire by the route selected. The stone could not be engaged in a lithotrite because of its size and close attachment of its surface to the wall of the cavity. The supra-pubic operation was at once begun. After the initial abdominal incisions access to the bladder was facilitated by a staff introduced, per urethram, to the anterior bladder roof. The finger of an assistant in the rectum was of much assistance in lifting the calculus so that the operator could separate it from its close environment in a sacculated portion of the bladder. When free, the stone was extracted with a pair of large stone-forceps. The bladder and wounds were washed with warm boracic-acid solutions and drained by both abdominal and perineal tubes. The patient came from ether with a fair pulse. At the end of two hours a marked change ushered in shock which terminated in death four hours after the operation. The stone weighed eight ounces. Its greatest circumference was nine inches; its transverse circumference was seven inches. The cavity of the peritoneum was not opened during the supra-pubic operation.

F. TILDEN BROWN.

Electropuncture in Chronic Hydrocele. DR. W. ZUELZER. (*Internat. Centralbl. f. d. Physiol. und Patholog. der Harn- und Sexual-Organe*, Band ii., Heft 2.)

This method of treatment, from which so much has been expected, has gradually lost ground, owing to the fact that recurrences took place in the vast majority of cases in which it was employed. Among the author's cases permanent recovery was observed in only one instance, although the application was made twice. He thinks, however, that the method is applicable in cases where the patient is so greatly debilitated that irritant injections or the radical operation are contra-indicated. Electropuncture is preferable to simple puncture, in that it is free from any ill effects; and this is due to the fact that the absorption of hydrocele fluid takes place slowly and gradually. The author employs two platinum needles which are coated with an insulating layer up to the point. Both are inserted, as far apart as possible, into the sac

of the hydrocele, connected with a constant battery: a current having a strength of 3 or at the most 4 milliampères is passed through them. The sittings should not exceed two to two and a half minutes. During the application active vermicular contractions of the scrotum are observed. The pain is inconsiderable if the current is not passed through for too long a period. In many cases after the removal of the needles and careful closure of the punctures, a gradual diminution in the size of the tumor ensued. Occasionally œdema of the scrotum occurred during the first few hours, which rapidly disappeared. Within eight days the fluid has been entirely absorbed, and by the employment of proper bandages and a snugly-fitting suspensory its reaccumulation can be prevented for a long time—in some of Zuelzer's cases for as long as six months. One of the advantages of the method is the rapidity with which it excites absorption, the quantity of urine being materially increased during the first twenty-four hours after the operation. In all the cases the inner surface of the sac was found covered with coagula as early as the first day, so as to be no longer transparent, and even when the fluid reaccumulated the characteristic translucency was never as marked as before. F. TILDEN BROWN.

Combined Percussion as a Diagnostic Auxiliary in Tumors of the Abdomen. DR. W. ZUELZER, Berlin. (*Centralbl. f. d. Physiol. und Patholog. der Harn- und Sexual-Organe*, Band ii., Heft 2.)

The author recommends the method of combined percussion and auscultation for the examination of the kidneys or of abdominal tumors covered with a thick layer of muscles. Differences in sound incapable of recognition by ordinary percussion can thus be determined. A metallic vibrating sound is given by organs containing air, such as the lungs and intestines. If we percuss over a solid organ, such as the heart, liver, kidneys, or over the muscles or tumors, or better still, if we percuss below the solid mass and auscultate above the opposite margin, a considerable interference with the sound conduction, or dulness, is appreciated. We can in this way map out the borders of the organ or tumor with greatest accuracy. To make out the boundaries of the bladder when filled with urine, it is sufficient to apply the stethoscope over an air-containing area above the bladder. In examinations of the kidney it is necessary to determine the external and inferior borders, and demonstrate whether dulness is produced by its presence. For this purpose the intestines should be as empty as possible: the stethoscope is placed upon the anterior abdominal wall, and percussion practised over the corresponding renal area: the patient bends slightly forward, supporting himself with his hands upon the seat of a chair. The percussion is commenced at the level of the fifth or sixth lumbar vertebra, over the spinous process, the bone yielding a clear resonance, and is continued toward the outside. In places where the kidney is covered by the muscles of the back the percussion dulness is most intense: it becomes distinctly clearer, however, as soon as we percuss beyond the margin of the organ. F. TILDEN BROWN.

Koch's Cure for Tuberculosis.

The interest in the new cure for tubercular affections grows from day to day both in the profession and among the laity. The clinical studies made in this city and elsewhere regarding the action of the remedy have been, so far

as they were made known, published in the weekly medical journals and in the daily press.

Many conflicting reports abound concerning the results obtained in the treatment of tuberculosis of the lungs and the internal organs, and only time and further investigation will be able to place an exact value upon the new treatment in these affections. In lupus, however, where the action of the lymph can be directly observed, some astonishing results have been obtained and a number of cures reported of long-standing cases of this affection.

Prof. Bergmann has detailed the results of his experience in thirteen cases of tuberculosis of the skin and oral mucous membranes. "These cases showed after injection the characteristic general and local reaction described by Koch. In particular the local manifestations were watched with care, and consisted in redness, especially well marked in the periphery of the affected area, and swelling, often very considerable. Both the redness and swelling extended in varying degree in different cases beyond the affected area. After each repetition of the injection the local reaction became less evident. The original seat of the lupus gradually became covered with crusts, sometimes of considerable thickness, which, when they were sufficiently advanced for removal or fell off, disclosed in a number of cases a perfectly smooth, delicate skin surface of no color, like that of a fresh scar."

The test of time must of course determine whether or not such apparent cures will be permanent, but from the reputed action of the lymph on the tuberculous tissue and not on the micro-organisms one would be justified in anticipating relapses. Should a return of the disease take place it would in no respect detract from the value of the injection or the claims of its distinguished discoverer. The specific influence of the fluid on tubercular conditions seems to be thoroughly well established, and the majority of observers agree regarding the diagnostic value of the lymph injections, as only in very exceptional instances have local or general reactions followed its use in non-tubercular affections.

Köhler (*Berliner klin. Wochenschrift*, I., Dec., 1890) reports a number of instructive cases in which its diagnostic power was brought into requisition.

A boy eleven years of age was treated for a doubtful ulceration of the skin, a part of which only could be healed by specific remedies.

Two ulcers of the thigh refused to heal, but extended at their periphery and bases, producing fistulæ and presenting every appearance of local tuberculosis. Several injections of the lymph were given, but although a rise of temperature was produced thereby, no change whatever was observed in the local affection.

The lymph was injected into several patients in whom apparent healing had taken place following extirpation of strumous glands; a local reaction was observed in the scar tissue over the former seat of a number of the glands, showing the presence of tubercular matter. As a *control* experiment several injections were given to a patient presenting an extensive scar following a burn, without producing a trace of reaction.

It will be readily seen from these results what an important agent we possess in the lymph, not only in diagnosticating obscure affections, but as a test of the success of our operative interference in tubercular troubles.

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Original Communications.

A CLINICAL STUDY OF PRURITUS HIEMALIS, WINTER ITCH, FROST ITCH, ETC.[1]

BY WILLIAM T. CORLETT, M.D., L.R.C.P. LOND.,

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THE affection under consideration was first pointed out as a disease *sui generis* by our esteemed countryman, Dr. Louis A. Duhring.[2] A year later, Mr. Jonathan Hutchinson also described, for the first time as he supposed, a "winter itch,"[3] since which time the disease has been little written about, and its *raison d'être*, aside from its association with cold, seems shrouded in mystery.

Doubtless this is largely due to the fact that the disease is seldom seen save in certain localities. It is rare in the southern States of America, where it is only seen during the influence of a cold wave. In the clinics of London "frost itch" is occasionally encountered, but the writer recalls not more than three or four cases during a period of three years.

In a recent work Dr. Payne speaks of frost itch as a rare disease of the skin and gives the history of four cases.[4]

In France it is so rare that cases are sometimes overlooked or their real nature not recognized. Thus during a winter sojourn of two months at the Hôpital St. Louis only one case of pruritus hiemalis was seen, and that was passed as a papular eczema. M. Quinquand, in

[1] Read before the American Dermatological Association, Sep. 3d, 1890.
[2] Phila. Med. Times, Jan. 10th, 1874. [3] Brit. Med. Jour., page 773, 1875.
[4] "Rare Diseases of the Skin," 1889.

commenting on this case, remarked on its rarity, and said that he did not recall a well-marked case of pruritus hiemalis in his service before.

The disease is met with in the northern parts of America, and especially along the chain of great lakes. The writer's observations during the past decade on the southern border of Lake Erie confirm the statement that in this locality it is a well-defined and not an uncommon disease.

The following report of three cases is made not on account of the rarity of the disease, but because the first is a careful record of a case extending over a period of twenty-two years, with observations, taken in various climes, illustrating the effect of locality.

In the second, the writer believes that certain etiological factors are brought out, while the third simply illustrates the affection in the negro.

CASE I.—L. R., male, aged 35, a native of northern Ohio, complains of paroxysms of itching during the winter months, most marked on retiring at night.

The family history is good excepting that it reveals a tendency to a cutaneous disorder: his father and an uncle on the paternal side were troubled with eczema. This they thought to be inherited from their grandmother, who was troubled with the same disease.

His previous condition and the onset of the pruritus is as follows: From ten to twelve years of age he was in delicate health from a functional derangement of the heart. At fourteen he had a severe attack of pustular eczema, which covered the entire surface of the body and which lasted about five months.

The second winter following, at the age of fifteen, he complained of the present disease for the first time. It was thought that the eczema was about to return, but there was little tendency to the formation of cutaneous lesions, and without any special treatment it disappeared the following spring.

About this time, and until twenty or twenty-two years of age, the patient was troubled with acne.

Aside from these functional and integumentary disorders he has been free from disease, and his general condition has been robust.

The itching, which had disappeared at the approch of spring and which remained away during the warmer months, returned the following autumn with the first sharp frost. And in this instance history has repeated itself with slight variations of severity ever since.

It was early noted that the severity of the pruritus depended on meteorologic causes rather than on any apparent variation of bodily condition. Thus in the winter of 1875–76, which was exceptionally mild, the pruritus was only occasionally present, and then to a slight degree. On the contrary, the winter of 1877–78 was cold, and the itching was sufficiently severe to seriously interfere with sleep.

These paroxysms appeared with regularity on removing the clothing for the night, and again, when severe, about four o'clock in the morning. After prolonged exposure to cold with high winds the itching continued during the night, and the nails were applied, even during sleep.

It was further observed that removing the clothing during the day-time induced an irritation of the skin.

The regions involved were the parts that came most in contact with the clothing—the anterior aspect of the thighs, the calves of the legs, and the upper part of the back. As the disease progressed it next appeared on the sides of the chest, abdomen, flexor surface of the forearms, and buttocks. In fact, the only regions of the body that were free during a severe attack were the parts protected from the cold and friction, such as the axillæ, folds of the nates and genitals. The unprotected parts—the face, neck, and hands—enjoyed a like exemption.

The effect of climate was further observed in the winter of 1878–79, which was severe, and the patient was additionally afflicted with lumbago. In January he left the North for Florida, and was gratified to find on retiring the first night after crossing Mason and Dixon's Line that the pruritus had disappeared. The lumbago lingered about a fortnight after reaching St. Augustine.

The winter following the irritation began as usual, and in the latter part of December the patient went to England. The pruritus was wholly absent during the voyage, but appeared in an irregular and somewhat mitigated form during the cold months in London. Two or three attacks of lumbago were also present during the winter.

The next winter, 1880–81, was severe both in England and France. This was his second winter in Europe, and some speculation was entertained as to whether or not the pruritus would appear.

All doubt was removed, however, early in December, when at the first suggestion of frost the itching began.

The patient then left England for France, and although the weather was colder on the Continent and he felt it more severely than in the Northern States of America, where greater preparations are made for keeping warm, yet he had no sooner crossed the Channel than the pruritus disappeared, and it remained away during his sojourn in France. He was also free from muscular rheumatism.

Returning to his home a year later, the pruritus set in with its accustomed ardor, but he thinks during the past six years it has somewhat abated in severity; otherwise it maintains the same general characteristics.

In the winter of 1888–89 a study was made as to the following points:

Meteorological conditions.
State of the general health.
Excretion from the kidneys and bowels.
Effect of internal medication, diet, etc.
Topical applications, clothing, etc.
Change of climate.

During the first three months of winter the patient's health was below its usual standard. Most conspicuous were gastro-intestinal derangements, with frequent "bilious attacks," which terminated in, or were supplanted by, a severe bronchitis. This gave an opportunity to observe the pruritus under varied conditions of health, as well as to test the effect of certain drugs administered internally.

The first note was made November 17th, at which time the temperature, which had been mild, fell to 34° above zero. The barometer registered 30.21, humidity 64.0, and the wind N.W. The skin was rough and irritable—"felt raw," as he expressed it.

The bowels were constipated, stools clay-colored; urine dark amber, sp. g. 1025, reaction acid, slight deposit of urates on standing, whole quantity passed in twenty-four hours 1,240 c.c.

He was given a pill of calomel and ipecac, gr. $\frac{1}{8}$ t. i. d., which was followed after two days by the fluid extract of rhamnus catharticus. This produced free evacuations. Pruritus severe.

November 21st.—Temperature stationary; patient feels quite well; excretory functions apparently normal; pruritus unchanged.

December 1st.—Weather mild, 40.0°; barometer, 30.4; humidity, 82.3; wind, S.W. Patient complains of slight nausea and dizziness, tongue coated. Was given pil. hydrarg. gr. v., followed by pulv. seidlitz. The day after he was put on the following:

℞ Acidi salicylici, ... ʒi.
Sodii bicarbonatis, ... ʒi.–ℑi.
Aquæ, ... ad ℥iv.
M. Sig. ʒi., t. i. d. post cib.

The diet was restricted to the following simple menu: Stale bread, toast, cracked wheat, fresh beef or mutton sparingly and but once daily, vegetables (except potatoes and beans), fruits, rice, and tapioca.

December 14th.—Weather stationary; itching slight, sometimes wholly absent.

February 1st.—Temperature, 23.4°; barometer, 30.6; humidity, 66.4; prevailing winds, N.W.; itching severe.

So far as can be determined by so short a test, the diet has had no appreciable effect on the pruritus.

The month of February was cold, with the prevailing winds from

the N. W.; the pruritus remained severe until the malaise of the past month terminated in a severe bronchitis, when it almost abruptly disappeared. It began to return, however, as the bronchitis subsided.

February 14th.—In New York, weather cold and dry; some itching at night. The eight days following were passed on the voyage to Liverpool; pruritus wholly absent, as in the two previous voyages.

The next fortnight in England, weather dry and frosty; pruritus in moderate degree.

During the winter the following countries were visited, with the effect noted: France, disagreeably cold and damp; no pruritus.

Switzerland, very cold with much snow; pruritus absent.

Italy, actually suffered at times from insufficiently-heated apartments, but not from the itching. There was much rain. The same is true of Austria and Germany.

The winter of 1889–90 being exceptionally mild in the Northern States of America, the pruritus was noticed but a few times, and at those times the wind blew from the lake, or N. W. It was found that wearing silk underclothing perceptibly mitigated the irritability of the skin.

The case is still under observation.

Case II.—C. K., male, married, aged 39, painter, has suffered from winter itch three years. He presented himself for treatment January 27th, 1890.

The history of the family shows him to be free from any inherited tendency to rheumatism, gout, or skin disease.

His condition previous to the onset of the disease has been exceptionally good. He has never been troubled with constipation, neither has he been subject to "bilious attacks."

He gave the following brief history of the disease: An irritability of the skin was first noticed three years ago, which appeared a month or so after donning his winter flannels. These were colored and stained the skin. The itching gave no special annoyance until the weather became cold, when it was very annoying on going to bed. In the spring it left him, but it has returned the two succeeding winters.

Last winter it was more severe than the present winter, which he attributes to the mildness of the season.

There is a feature in this case, which has been seen, but to a less extent in others, to which I especially wish to call attention. It is the appearance at times of urticarious plaques. They precede the itching; are confined to the extremities; are of various sizes up to two or three inches in diameter; elevated; at first white, they subside in about ten minutes, leaving a dark red spot which gradually fades away. Their appearance is irregular—sometimes at intervals of a week, sometimes but a few times during the season.

CASE III.—L. H., a negress, single, aged 23. Presented herself at the polyclinic February 24th, 1890.

There was nothing in the family history bearing on the case.

She said she had always had a rough skin during the cold weather, but it had been free from itching until the previous winter.

The only point in this case worthy of note, as it followed the usual course, is its presence in the negro, who it appears is not exempted, although this is the only case I have met with.

In regard to the etiology of pruritus hiemalis, there seems to be a difference of opinion. Some maintain, with the late Dr. Tilbury Fox, that it is due to internal causes, such as the imperfect oxidation of food, the imperfect elimination of nitrogenous substances,[5] as well as the retention in the system of biliary products. He further observed that it was usually met with in gouty subjects.

Diakonoff,[5] quoted by Anderson,[6] says that it consists primarily in an abnormal irritation of the cutaneous sensory nerves, which in a reflex way, through the sympathetic ganglia and vaso-motor nerves, brings about a localized paralytic dilatation of the cutaneous capillaries, with a subsequent disturbance in the nutrition of the sensory nerves.

An editorial[7] on the prevalence of an epidemic of winter itch in Memphis, Tenn., brought out the history of the disease as it occurred in two medical men. One gave as an exciting cause prolonged exposure to severe cold after violent exercise. Thenceforth it appeared with the yearly advent of frost.[8]

The second case was a resident of Michigan, who first contracted the disease while passing the winter in New York. It recurred the winter following, he having returned to his home, and it had recurred the nine succeeding winters up to the date of the report.[9]

In reviewing the history of these cases it will appear: First, that the state of the general health had no appreciable effect on the pruritus. Thus Case I. during the months of November and December, 1888, and January, 1889, when impaired health indicated the imperfect oxidation and elimination, as well as the retention of biliary products, already referred to, still the pruritus was in no way more severe than at other times, when the patient appeared in vigorous health and the excretory functions were normal. Further observation bears out the statement that these conditions are not more frequently met with in the subjects of pruritus than in those free from any cutaneous disturbance.

Second.—The local irritation of the clothing, as in Cases I. and II.,

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[5] Lond. Med. Record, June 15th, 1886. [6] "Diseases of the Skin," 1887.
[7] N. Y. Med. Record, Jan. 14th, 1888. [8] N. Y. Med. Record, March 3d, 1888.
[9] N. Y. Med. Record, April 14th, 1888.

although capable of aggravating the malady, is not of itself able to produce it.

Third.—Meteorological conditions appear to furnish the main etiological factor. These were most potent with a low temperature, low humidity, and the wind blowing from the north-west. The greater the velocity of the wind, *cæteris paribus*, the more severe the itching.

These influences are favorable to evaporation, and the low temperature reduces the glandular activity of the skin to a minimum. As a consequence the skin becomes harsh, the peripheral nerves are irritated, and the disease is induced.

Against the theory of local irritation it may be said that those parts that are directly exposed to atmospheric influences, as the face and hands, are seldom if ever attacked. Nor does the wearing of sleeveless undershirts aggravate the pruritus of the arms, as occurred in a case which comes to mind.

May we not account for this from the fact that these surfaces become hardened by constant exposure; that they enjoy an immunity to external agencies that parts constantly protected and sometimes bathed in perspiration cannot attain?

Again, the question arises whether the primary irritation may not be central; that is, in the posterior columns of the cord. Manifestly, from what we know of lesions in these parts, this is not the case; for the continued disturbance of nerve centres would, in time, give rise to a less fleeting disease. The same holds true, although to a less extent, of any internal exciting cause.

Fourth.—Pruritus hiemalis is not infrequently associated with other neuroses of the skin. This is well marked in Case II. These neuroses probably have no influence other than simply showing the peculiar susceptibility of the nervous system.

The treatment of pruritus hiemalis is largely palliative. Internal medication seems to have little effect. In the writer's experience the only drug that has given promise of success is ichthyol; but as it was given in connection with local applications, it is impossible to say how much credit it actually deserves.

Of local measures resorcin has been found the most beneficial. It tides over the irresistible desire to scratch, its influence remains from two to five hours, and not infrequently it affords immunity for a whole night.

The following is the formula used:

℞ Resorcin (Merck's), ... ʒ i.
Glycerin, ... ʒ ij.
Aquæ, ... ad ℥ iv.
M. Sig. Apply.

Menthol has also been serviceable in this affection.

℞ Menthol, ... 10 p.c.
Glycerin, ... ʒ ij.
Aquæ, ... ad ℥ iv.
M. Sig. Apply.

Ichthyol, although less agreeable to use, has been highly beneficial in a few cases.

℞ Ichthyol ammon. sulph., ... 3–10 p.c.
Glycerin, ... ʒ ij.
Alcohol,
Aquæ, ... āā q. s. ad ℥ iv.
M. Sig. Apply.

These applications have been called palliative, yet it is not very uncommon to see cases of pruritus hiemalis get well under their use. Change of climate, however, seems to be the only curative means at our command; but as few are able to avail themselves of this, it must ever be of secondary importance.

From the foregoing it will further appear that in selecting a climate, one not subject to sudden changes should be chosen. Warmth and humidity are also essential.

333 PROSPECT STREET.

BASSORIN PASTE: A NEW BASE FOR DERMATOLOGICAL PREPARATIONS.

BY GEORGE T. ELLIOT, M.D.,

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SOMEWHAT over two months ago Mr. Lascar, the pharmacist of the Demilt Dispensary, called my attention to a preparation which he had made in the course of investigations undertaken with a view of finding a substitute for the gelatin base recommended and advocated by Unna and others, one certainly of great value and use, but yet open to more or less well-grounded objections, owing to the difficulty of obtaining a good article, at least here—the waste of time required in its application, the necessity of heating the mass every time it is used, the many visits entailed on the patient by the fact that it has to be applied by the physician, etc. Mr. Lascar was of the opinion that all such objections were fully met by the base which he showed me, and he requested me to try it in such diseases as I deemed appropriate, stating that he would gladly, after the trials, make whatever changes I considered necessary, and follow any suggestions

which I thought advisable in the preparation of the mass, in order to make it answer all requirements. The first sample furnished did not, however, fulfil the expectations entertained. I found it to be of too fluid consistence, it would not dry completely and form a suitable and flexible coat on the skin, and it did not adhere to the surface upon which it was spread. On the contrary, it could be rubbed off with ease. At my suggestion, therefore, the proportions of the various ingredients were changed by Mr. Lascar, and in order to make it adhere better, a certain percentage of dextrin was added.

The exact formula of this base, and the precise proportions of each ingredient entering into its composition, I will not give here, but will leave that part of the subject to Mr. Lascar, who will unquestionably soon make it public in the columns of one of the pharmaceutical journals. I may, however, say that the prime and important constituent of the base is bassorin, a substance which is defined in Dr. Foster's Medical Dictionary as "belonging to the class of vegetable mucilages derived from Bassora gum tragacanth and other sorts of gums; tasteless, odorless, and almost colorless; insoluble in cold water and swelling up into a viscous mass when treated with hot water. On being heated with aqueous solutions of alkalies it is converted into a gum soluble in water, and by treating with sulphuric acid it is transformed into a non-fermentible sugar." With this substance, bassorin, then, the remaining ingredients of the base—water, glycerin, and dextrin—are mixed in the proper proportions, and the compound to which the name bassorin paste can be given is thus obtained. When composed alone of the substances mentioned, bassorin paste is of the consistency of a jelly, tawny in color, resembling somewhat vaselin. It has no particular odor, is absolutely neutral in reaction, does not decompose even when kept a length of time: a sample in my possession has been kept six weeks and is the same as though prepared yesterday. If kept in damp places mould may, of course, develop on the exposed surface of the paste, but yet the paste itself does not seem to undergo change. Owing to the property it possesses of drying when exposed to the air, the bassorin paste should be kept in well-closed jars, preferably of glass, but even when it has hardened, rubbing it up again with a little water makes it as good as at first. The base does not come off when once dry on the skin, and thus soiling of the linen or bedclothes is avoided. Should it be desired it can at any time be easily removed by washing with a little water, a damp sponge, or absorbent cotton.

Almost any drug may at will be incorporated with the bassorin base. If the one used be soluble in the water contained in the paste, the color of the latter is unchanged, but if insoluble, then the color will vary according to that of the substance added to it. Those drugs

which exist only as fluids cannot be mixed, however, with the base, and neither can alcoholic solutions; but fats may be, yet to a limited extent. The former are excluded for the reason that they render the base too liquid, and the alcohols cause it to become brittle and hard. The proportion of the fats must be small, for the reason that if large, they would impair the property the paste has of drying and adhering to the skin. All substances, however, which exist in a solid form are easily incorporated with it in proportions as large as are ever used or found necessary. For instance, zinc oxide may be mixed with the base to the extent of thirty or more per cent; carbonate of magnesia, ten or more; chrysarobin, fifteen or more; salicylic acid, salicylate of soda, iodoform, resorcin, boric acid, borate of soda, sulphur, etc., etc., each and all incorporate perfectly with the bassorin paste and without changing its nature or its properties. The percentages of the tars do not, however, go as high on account of their oily nature, but yet I have found that pix liquida, oleum rusci, and also ichthyol could be added successfully to the amount of fifteen per cent. When the tars and oily drugs are used, it is advisable to incorporate with the base ten or more per cent of zinc oxide also, or of some neutral powder, as chalk, wood pulp, etc., so as to counteract any possible impairment of the base's characteristics. Combinations of two or more drugs can be added to the mass, as well as any single one, and in fact its use as a base is practically the same as that of an ointment. Salicylic acid and oxide of zinc, the former and chrysarobin, or hydrargyrum ammoniatum and aristol, or zinc oxide, magnesia carbonate, and ichthyol, etc., etc., have been respectively combined by me with the bassorin base without observing any differences between the resulting compound and the same drugs mixed together with some ointment or other as an excipient.

The action of the substances incorporated with the bassorin base has appeared to me to be eminently satisfactory, as good as when they are used in the form of an ointment or in collodion or liq. gutta percha or gelatin. Whether it has been resorcin in a seborrhœic eczema, or chrysarobin in psoriasis, or ichthyol for a parasitic eczema, or pix liquida for a chronic squamous one, or whether the process on the skin has been acute or chronic, yet the results obtained have been just as good as when any one of these remedies has been used in some other excipient. For the most part, I would say that the effect has been better, especially as regards ointments or lotions, for the reason that the remedy remains in constant contact with the diseased skin when mixed with the bassorin paste, and this base being absolutely without any irritating properties, it is of much wider applicability and service than the collodions or traumaticins. As far as I may judge

from the effect of the paste upon disease, it does not prevent absorption by the skin of drugs incorporated with it, and it likewise takes up in certain degree any moisture which may be present upon the skin.

In its use there is the greatest simplicity. The drugs indicated by the disease being added to the base, the paste can be rubbed over the surface by means of the finger or a soft varnish-brush—a camel's-hair brush is too yielding and soft to be of service. The amount applied may be made as great or as small as desired, but I have found no advantage to result from using thick coatings. On the contrary, enough to cover the surface uniformly is all that is necessary; more may be painted on, but it then requires longer to dry and its outer layers are more liable to peel off. After the paste has been applied, exposure to the air for a few minutes—the time varying according to the thickness of the coating, but being usually about five minutes—is sufficient to have it dry thoroughly, and it then represents a flexible adherent covering for the skin, one which, moreover, sticks so effectually that it withstands brisk and forcible rubbing, or as a patient expressed it after having spent half a day trying to pick the paint off, "it sticks like paper on a wall." The length of time that the paste will remain without scaling off or cracking will naturally depend upon the condition of the surface upon which it has been applied. I have seen an ichthyol or tar bassorin paste remain *in situ* and without change for four days, when the portion of skin which either one covered was neither moist nor exposed to very great friction from the movements of the body. When more or less moist exudation, however, is present and a feature of the disease being treated, the paste ought to be applied freshly every twelve hours at least, or if necessary even oftener—every three or four hours. On the whole, it may be said that once in twelve hours or in twenty-four hours is sufficiently often to renew the dressing, though, as already mentioned, one should be guided by the conditions existing on the surface treated. In situations such as the inguinal region, the anal furrow, the axillæ, etc., it is best to separate the parts painted with the bassorin paste by a thin layer of absorbent cotton or other protective, as the rubbing together of these surfaces would be apt to remove the dressing.

The usefulness of the paste is limited only by the degree of moisture or of exudation on that portion of the skin to which it is to be applied. When such conditions exist in great amount, it would be difficult to obtain complete adherence of the base, for the reason that water softens it and would prevent its drying. If only a slight or medium amount, however, of exudation be present, the use of the paste is not contra-indicated and the moisture may be overcome, es-

pecially if such hygroscopic substances as carbonate of magnesia, or starch, or kieselguhr are added to it in the proportion of ten to fifteen or more per cent. The base is also applicable in cases of vesicular or pustular eruptions if the lesions are still intact or if only comparatively few have ruptured—that is, if the amount of moisture is not so great that the consistency, the drying and adhering properties of the bassorin compound will be impaired. On surfaces exposed and liable to contact with water or other fluids, it is also evident that the bassorin cannot be always used, as the result would be its speedy removal. I have seen this occur on the hands of patients when they became wet from rain or from some other cause, but inasmuch as it does not rain all the time and avoidance of wetting is easy, such occurrences cannot be looked upon as prejudicial to the value of the paste.

Perhaps the most extended use of the bassorin base, however, will be in those inflammatory and other processes on the skin which are dry, squamous, and unaccompanied by much moist exudation, in some of the parasitic diseases, in those requiring protective action and when the constant effect of the remedy is desired. I have already tested it in quite a large number of such cases, among which may be mentioned several forms of eczema, acne, psoriasis, and syphilis, and always with the best results. My patients, especially in private practice, have extolled its praise in the highest terms, on account of the freedom from the disagreeable characteristics of ointments which it allows, and in consequence the treatment prescribed has been followed with greater care and less distaste. As instances, I would mention the following cases:

CASE I.—Acute papulo-vesicular eczema of the trunk and extremities. The patient was first seen December 13th, 1890. On the arms alone, ℞ Acid. salicyl., gr. 15; zinc. oxid., gr. 50; bassorin paste, ℥ i. M. et S., was to be used, while for the rest of the body an ointment containing the same ingredients was ordered. December 14th the paste was still *in situ* on the arms, and when removed the eruption was seen to have subsided in great part. Itching and burning was said to have ceased after it had been rubbed on. Improvement had also occurred where the ointment had been used, but to a much less degree, the patient complaining of the itching and burning and greasiness. I directed him to use the bassorin paste over the entire surface once in twenty-four hours. On December 19th he was entirely free from the eruption.

CASE II.—Eczema of the fingers, papulo-vesicular and squamous in character and of long duration. Patient had been continuously for over a year under the care of several physicians besides myself. Salves, lotions, and gelatins, as well as internal treatment, had been used, but the results were far from satisfactory. When I saw him, on

November 15th, the eruption was markedly present on the first three fingers of each hand and the thumbs, squamous in character, with small areas of papules and vesicles and points of weeping here and there. He was given ℞ Picis liquidæ, ʒ i.; zinc oxide, gr. 40; bassorin paste, ℥ i. M. S. Apply once daily. The improvement was immediate and he is now (January 4th, 1891) free from the disease for the first time since its inception.

Case III.—Eczema seborrhoicum of the inguinal regions. Patient was seen December 7th, 1890, one week after he had noticed the eruption. It consisted of large, circumscribed, slightly reddened patches, covered with moderately thick yellowish and brownish fatty crusts. A marked condition of pityriasis was present on the scalp. For the patches he was given ℞ Resorcin, gr. 25; bassorin paste, ℥ i. M. S. Apply once in twenty-four hours. The surface was to be washed every day with soap and water before the paste was applied. On December 14th only slight traces of the disease remained, and a week later it had entirely disappeared.

The same speedy and effectual result was obtained also on a baby presenting the same manifestations of seborrhœic eczema in both axillæ and inguinal regions, a very short time being required for the removal of the eruptions.

Case IV.—Psoriasis. Patient had been treated with unguenta, chrysarobin collodion, tar tinctures, plasters, without satisfactory results. I gave him ℞ Olei rusci, ʒ iss.; zinc. oxid., ʒ i.; bassorin paste, ℥ i. M. Sig. He found it was only necessary to apply the paste once in forty-eight hours. It remained adherent for that length of time without cracking or scaling. Beginning the treatment December 2d, he has in four weeks obtained more improvement in the rebellious, chronic, thickened patches—on the backs of the hands, legs, and thighs—than he had from all the other forms of treatment which had been made use of for four months previous.

Besides these cases, a number of others were treated in private practice with the bassorin paste, and with most satisfactory results. Seborrhœic eczema in various situations, irritation and reflex eczemas, acne, psoriasis, etc., were most satisfactorily influenced by the treatment, and besides, the same good effects were obtained in hospital service. Eczema, psoriasis, syphilis, etc., were treated by means of the base, both in the wards of the New York Skin and Cancer Hospital and in the Out-door Department. In these also its application was found to be easy. It adhered so well to the skin that on some renewal of the paste was made only once in forty-eight or seventy-two hours, and a more efficacious dressing could not have been used.

Case V.—Syphilis gummatosa cutanea. The lesions were situated on the forearms and consisted of cutaneous gummata and groups of

large resolving papules. Over a portion, the treatment followed before she came to the hospital had caused an outbreak of eczema, and weeping and formation of thin crusts had developed. On her admission she had had applied a dilute ungt. hydrargyrum (3 ij.: ℥ i. ungt. oxidi zinci), but it intensified the eczema after a few days and I ordered it to be discontinued, and on December 13th, 1890, prescribed ℞ Ichthyol, gr. 10; pulv. zinc. oxid., gr. 50; bassorin base, ℥ i. M. At first there was a certain degree of smarting produced, but by the 21st the eczema had healed, the eruption was noted as fading marvellously. She was taking at the same time mixed treatment. To-day (January 3d, 1891) there is only slight diffuse thickening of the skin where the eruption had been. In the out-door clinic, a case of acute vesicular eczema of the palms was treated with wonderfully quick effect; also one of chronic erythematous eczema of the face, of acne, etc. The results in all were surprisingly good.

The bassorin paste has been used by me in the following combinations among many others:

℞ Acid. borici, 3 i.–3 ij.
Oxid. zinci, 3 i.
Bassorin paste, ℥ i.
M. et S.

℞ Aristol, gr. 25–50.
Bassorin paste, ℥ i.
M. Sig.

℞ Chloral, gr. 30.
Camphor, gr. 40.
Zinc. oxid., 3 i.
Bassorin paste, ℥ i.
M. et S.

℞ Acid. pyrogallici, gr. 25.
Acid. salicylici, gr. 10.
Bassorin paste, ℥ i.
M. et S.

℞ Olei ruscі, 3 i.–3 ij.
Zinc. oxid., 3 i.–3 iss.
Bassorin paste, ℥ i.
M. et S.

℞ Hydrarg. ammoniat., gr. 20–50.
Oxid. zinci, 3 i.
Bassorin paste, ℥ i.
M. et S.

℞ Resorcin, gr. 25–3 ij.
Bassorin paste, ℥ i.
M. et S.

℞ Resorcin, gr 20.
Sulph. lactis, gr. 40.
Bassorin paste, ℥ i.

℞ Zinc. oxid.,
Magnesiæ carbonat., āā 3 i.
Bassorin base, ℥ i.
M. S.

℞ Picis liquid, 3 ss.–3 ij.
Oxid. zinci, gr. 50.
Bassorin paste, ℥ i.
M. S.

The brief description of the bassorin compound given will, I think, sufficiently delineate its principal characteristics and its value and applicability in the treatment of cutaneous disease. In conclusion, I would summarize these as well as the advantages it seems to me to possess over other excipients in more or less general use.

1. Bassorin paste is a perfectly neutral substance which of itself

produces no irritation whatever, and when used alone it acts simply as a protective to the skin. It does not become rancid or decompose or undergo change when kept for a length of time, unless it be exposed in an open vessel. When this is done it becomes dry and hard, but even then rubbing it up with a little water renders it again as serviceable as at first.

2. It is easy and simple in application, requiring only to be spread upon the skin with the finger or a brush. It dries in the space of a few minutes if so applied, adheres closely, does not rub off and soil the linen, but forms a flexible coat, which does not interfere with the movements of the body. When its removal is desired, the preparation can be washed off with a little water or a damp cloth or sponge. It remains *in situ* without change for a variable length of time, depending upon the condition of the surface on which it has been applied.

3. With the bassorin paste almost any drug can be incorporated; those which exist in the form of powders or in solid forms in any amount desired; the tars, ichthyol, and oily substances in smaller percentages, but sufficient for all practical purposes.

4. The action of drugs incorporated with it and their effect upon disease appears to be as good as when such are used in other excipients—or perhaps better in some cases.

5. It is of wide applicability, and of value in both acute and chronic forms of disease, its use being limited only by the degree of moisture on the surface being treated or to which it may be exposed.

These properties possessed by the bassorin paste render it, as may be seen, superior to ointments, for the reasons, among others, that it is difficult to keep the latter in constant contact with the diseased surface; that salves soil and stain the linen, and offer such other objectionable features as greasiness, risk of becoming rancid, etc., to say nothing of the discomfort entailed upon the patients using them. It is also of wider application than the collodions and traumaticins, owing to the irritation of the ether and chloroform contained in them, their contractile property, the limited extent of surface over which they can be applied, and the difficulty experienced in removing them when desired.

The bassorin paste would seem to be also superior to the gelatin preparations, in that these latter are more or less cumbersome in their application, having to be heated freshly whenever used, entailing a waste of time and also frequent and practically unnecessary visits by the patient. Drugs incorporated with the gelatins have also seemed to me not to act as favorably upon disease as when mixed with the bassorin base.

7 West 31st Street.

SEPTIC INFECTION FOLLOWING URETHRAL OPERATIONS—REPORT OF A CASE.

BY SAMUEL ALEXANDER, M.D.,
Surgeon to Bellevue Hospital, etc.

THE various forms of septic infection included under the title urethral or catheter fever are a subject of interest to every genito-urinary surgeon. I shall therefore offer no excuse for adding to the already long list of the published cases of this kind the following report of one which presents certain features which are peculiar:

On November 17th, 1890, William O'B., a native of Ireland, 41 years of age, was admitted to Ward 15 of Bellevue Hospital, suffering from retention of urine.

He gave the following history: Prior to 1863 he had had several attacks of gonorrhœa, each of which lasted a number of months. In 1863 he again had a urethral discharge, and during the attack began for the first time to experience difficulty in passing water. The stream became very small and he had partial retention, for the relief of which he entered Bellevue Hospital. There he was treated for stricture by dilatation. Upon his discharge from the hospital a sound (size unknown) was given to him, and this he continued to pass at irregular intervals until 1874—a period of nearly eight years. He discontinued the use of this instrument, believing that he had been cured. He remained well until 1883, when he again began to have difficulty in passing water. This increased, and during the year he again had retention, for the relief of which he entered the New York Hospital. There he was treated by internal urethrotomy. After leaving he drank to excess, and in three months again had retention, and was cut internally for the second time.

After this operation he remained well until the autumn of 1889, at which time the difficulty in micturition returned. His symptoms slowly increased. In February last he fractured his leg and was sent to Charity Hospital. During his stay there he was cut externally in the perineum. He left the hospital last April or May, apparently well.

In October his symptoms began again to trouble him, and during that month he passed water only with great difficulty. The urine became foul and was loaded with pus. The desire to micturate recurred with great frequency.

On November 17th he had complete retention, having passed but little urine on the 16th.

On admission to the hospital he said that he had been drinking hard for more than a week. He was extremely restless, and it was feared that he would develop delirium tremens. His pulse was good, but rapid. The bladder was distended with urine, and the area of vesical dulness extended some distance above the pubis.

After failure to enter the bladder with a soft instrument, a filiform was passed through the stricture, over which a No. 6 F tunnelled catheter was guided into the bladder. About 20 ounces of bad-smelling ammoniacal urine was drawn off. No blood followed the withdrawal of the catheter. An anodyne was administered and the patient was left for the night.

I saw him for the first time the following morning, November 18th. He was very shaky and nervous from the effects of drink, and had passed no water during the night. His bladder was distended above the pubis.

In examining the urethra I found a stricture at the bulbo-membranous junction, through which I passed a filiform guide and drew off about 22 ounces of ammoniacal urine, which was loaded with pus, and as the stream ceased there was a drop or two of bloody pus. For the purpose of insuring the right of way into the bladder, I then passed a No. 10 F catheter over the guide. This was grasped firmly, and its withdrawal was followed by a few drops of very dark blood. Before taking out the catheter I washed the bladder with a hot solution of Tiersch's fluid. A sedative was ordered and a full fluid diet, with Poland water *ad lib.* The urine was examined and showed a sp. gr. 1.022; reaction alkaline or neutral; ten per cent by bulk of albumin; pus, a little blood, and bacteria. During that day the patient was drowsy and restless by turns. His bowels moved twice and urine was passed with each movement. The amount of the latter was not ascertained. On the day following, November 19th, at 7 A.M., the patient had a severe chill, followed by fever; the temperature reached 105⅗° F. at 9 A.M. The patient became very restless and was somewhat cyanotic; was greatly depressed; pulse 160, very feeble; tongue dry and brown. He had passed no urine during the night, and percussion revealed an empty bladder. This condition continued for several hours. Under active stimulation and the administration of large quantities of fluid the patient, in some respects, showed gradual improvement. At 12 A.M. he was rational, but seemed dazed; pulse 120; temperature 104¾°. A small quantity of urine had passed through the urethra. The improvement continued, and at 10 A.M. November 20th, about thirty hours after the chill, the temperature was normal.

The following note was taken at this time: General condition improved; temperature 98½°; pulse 90, weak; mind cloudy, but when roused the patient answers questions intelligently; tongue dry and brown; bladder apparently empty; no record of the passing of any urine during the night.

His condition remained the same during the day, but he complained of chilly sensations late in the afternoon and of a soreness over the left breast.

The following note was taken at 11 A.M. November 21st:

During last night patient was very restless; passed little if any urine. At 1 A.M. temperature 100°, at 9 A.M. 97½°. An examination of patient shows on the left breast, two inches above the nipple, a gangrenous spot two inches in diameter, circular in form. The sur-

rounding tissues are reddish; pressure causes emphematous crackling, and the entire breast has a boggy feeling.

On the left buttock, over the tuber ischii, is a similar spot of gangrene, but larger than that on the breast—three and one-half inches in diameter.

On the right buttock is another spot rather smaller and not so far advanced. The patient is slightly delirious and seems dazed; pulse feeble; temperature 97½°. He is greatly depressed; complains of intense thirst; bladder empty. These spots of gangrene have appeared certainly within the last eighteen hours.

Through fear of running a risk in keeping such a case in the wards, he was transferred to the erysipelas pavilion in the hospital grounds. The gangrenous spots were incised, and discharged a thin brownish fluid, having a putrid odor. The sloughs were scraped away, exposing the muscles beneath, and the wounds were dressed with aristol and poulticed with charcoal.

The full notes of the case since the patient was transferred I have not been able to obtain, owing to the absence of the surgeon in charge. Before the operation the temperature rose to 102° F., and continued to vary between 102° and 99½° F. until December 3d, when it fell to normal and has remained so ever since. The suppression of urine continued for about twelve hours after the patient was transferred from the wards. He had a mild delirium during the first week, with a weak pluse of about 90.

Shortly after the wounds had been scraped they began to granulate, and are now rapidly filling up.

The following note was made to-day: Patient's general condition good; temperature 98½°; appetite satisfactory. The wounds on the chest and buttocks are healthy and are granulating rapidly. The urine still contains pus, and is passed in a small stream but without difficulty.

This case is a striking example of the danger of septic infection after catheterism, internal urethrotomy, and the like, in cases of stricture of the deep urethra with ammoniacal or fetid urine. Owing to this danger I have almost given up treatment by dilatation in such cases, and prefer to perform at once the external perineal operation with vesical drainage, in the manner suggested by Mr. Harrison, of Liverpool.

In this way the stricture can be at once disposed of and the bladder thoroughly disinfected and drained. The use of the perineal tube prevents contact of the urine with the urethra. Up to the present time I have treated in this manner more than thirty cases of stricture in which the urine was ammoniacal or fetid. In all of these there was partial or complete retention of urine.

In none of the cases has the operation been followed by urethral fever, and the results obtained have been most satisfactory.

On the other hand, in the few cases of this kind in which any attempt has been made to dilate the stricture, urethral fever has been the rule rather than the exception.

In the case which I have just reported I did not operate at once, owing to the patient's threatened attack of delirium tremens.

Of course it is impossible to say what the result of operation would have been, but with my present experience I should prefer to operate immediately in a similar case.

A CASE OF ATROPHIA MACULOSA ET STRIATA FOLLOWING TYPHOID FEVER.[1]

By FRANCIS J. SHEPHERD, M.D.,
Surgeon to the Montreal General Hospital.

TEXT-BOOKS on skin diseases, although they mention briefly the occurrence of this affection, take no notice of the fact that it is occasionally a sequela of acute diseases, especially in the young. This circumstance affords me an excuse for relating the following case.

Alex. C., æt. 15, was admitted into the Montreal General Hospital under Dr. Tholson, on September 15th, 1889, suffering from a severe attack of typhoid fever. The fever ran the usual course, but was followed by a number of disorders, such as inflammation of both parotid glands, paralysis of the right facial nerve, paresis of the lower limbs, and fits of an epileptic character with a mild form of dementia. About the middle of November curious transverse, colored stripes were noticed above the knees of both legs. It was not known how long they had existed: they were certainly not present some weeks before. When I first saw the patient, toward the end of December, the striæ were well marked. They were situated above both knees and over both patellæ, purplish in color, elliptical in shape, tapering to a fine point at each end; in direction transverse to the axis of the limb and parallel to one another. The largest of these stripes was about six inches in length and half an inch in breadth at the widest part, viz., the middle. On the right side there were two well-marked parallel stripes and several intermediate smaller ones; a short broad one ran across the patella. On the left side there were no less than five of these stripes, of various lengths and widths, some being mere narrow lines. Over the left patella was a large irregular collection of

[1] Read before the American Dermatological Association, Sept. 4th, 1890.

smaller striæ which seemed to run into one another. In addition to these colored stripes were several depressed spots of shiny skin, from the size of a split pea to that of a bean.

The striæ were of a purplish-blue color, much deepened by continuance in the erect position, and resembled scars from burns. The skin was smooth and glistening, somewhat puckered transversely and devoid of hairs. All the striæ were perfectly sensitive. On passing

the finger over them the sensation of a depression was communicated, the skin feeling dry and thin. When the knees were flexed the striæ had a distinctly depressed appearance.

During the time the patient was under observation (some three months) fresh spots and striæ appeared. These did not follow the course described by Liveing—there was no first stage of hypertrophy. On the contrary, the first condition noticed was the appearance of shiny, depressed, cicatricial-looking spots which gradually enlarged;

several seemed to coalesce, and uniting would form a stripe. At first their color was reddish, but afterward became a purplish-blue. Before the boy left the hospital, in March, the older striæ were of a decidedly lighter color. Since his dismissal from hospital he has been lost sight of.

The interesting point about this case is the fact that this affection followed typhoid fever. Manouvriez and Bouchard have recorded such cases, and Troisier [2] has noticed the disease in children and young adults. He states that Bouchard considered that the striæ were due to stretching resulting from rapid growth after the subsidence of the fever. Troisier and Menetrier have demonstrated that the elastic tissues of the skin are less thick at the level of the atrophic area, but they failed to find any real evidence of true atrophy; the elastic fibres were simply torn through and curled up at their broken ends. In girls the breasts and iliac crests seem to be the favorite sites, but in boys these atrophic lines have no special distribution.

Bradshaw [3] reports a case in a girl æt. 13, somewhat similar to the one related above. There were some horizontal parallel markings, five or six in number, on the anterior surface of the lower third of the thighs and patellæ. The longest reached about one-third the circumference of the limb; they were pointed at their ends and almost precisely similar on both thighs.

Dr. Samuel Wilks, in Guy's Hospital Reports for 1861, figures a typical case of "*linear atrophy*" of the skin about the knees in a boy, aged 19, who was admitted into Guy's Hospital for strumous disease of the knee-joint. The striæ existed on both knees and had been noticed for some time, but the fact of their following fever is not alluded to. He also describes another case in a girl, æt. 18, who had these striæ all over the body, but especially on the legs. In this case they appeared at first as faint red spots, which afterward became purple and subsequently dead white. These marks were very tender and sensitive, the patient shrinking when they were touched.

These atrophic striæ, or "false cicatrices" as Virchow calls them, have also been noticed after typhus fever by Plagge.[4] They occurred on the abdomen where there had been no distention of the parietes. He thought them due to atrophy from defective nutrition. They occurred in cases where there was great emaciation and were preceded by no infiltration or abnormal coloration.

As to the cause of these striæ, this is somewhat difficult to determine. That they are due to stretching from rapid growth is possible and plausible, and the evidence of the microscopic examination by

[2] Bulletin de la Société Médicale des Hôpitaux, No. 12, 1888.
[3] British Med. Jour., July, 1888.
[4] Zeitschrift für die Staatsarzneikunde, vol. xv., p. 369, 1861.

Troisier and Menetrier points in this direction. But again, how can we explain these striæ occurring in the breast, which had not grown or been distended, but rather has been the subject of shrinking after fever? In Plagge's case narrated above he distinctly states there was no distention of the abdominal parietes, but on the contrary there was great emaciation, and yet these atrophic lines were abundant. Many, including Schwimmer, look upon this affection as of tropho-neurotic origin. This would explain the symmetry, and certainly in my case there was considerable neurotic disturbance. Nearly all the cases noticed following fever have been where the disease was severe and prolonged. Barié[5] reports a case which followed herpes zoster and considers this conclusive of its neurotic origin. Kaposi[6] has examined the skin in these cases and found the epidermic layer and the mucous layer much atrophied. The papillæ had entirely vanished, blood-vessels few, and fat-cells absent.

Langer[7] asserts that these lesions are not due to rupture, but to disarrangement of the connective tissue. The connective-tissue bundles form rhomboid meshes, which when the integument is distended stretch most readily in their long axes. He says the striæ are the result of violent stretching, the bundles in part becoming parallel and remaining in position.

The discordant views of the French and Austrian observers regarding the actual condition of the parts as they appear under the microscope render it probable that the disease may be produced by various causes. Certainly over-stretching does not explain all cases, though no doubt affording a true explanation in many, and in certain cases we must look to a tropho-neurotic cause to explain the condition. I regret that I was unable to procure a specimen for microscopical examination in my case, but the patient's condition would not admit of it.

Society Transactions.

NEW YORK ACADEMY OF MEDICINE.

SECTION IN GENITO-URINARY SURGERY.

DR. FESSENDEN N. OTIS *in the chair.*

Tumor of the Scrotum.—DR. GERSTER presented a specimen of an enormous tumor of the scrotum which he had removed at Mount Sinai Hospital on December 5th, 1890. The following is the history of the case:

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[5] La Semaine Médicale, p. 259, 1888.

[6] Hebra: "Diseases of the Skin," N. S., vol. iii., p. 262.

[7] Anzeiger der kk. Gesell. der Aerzte in Wien, No. 28, 1879.

Aaron C., aged 45, married, five children, admitted December 3d, 1890, to Mount Sinai Hospital. He had a gonorrhœa at 20. There is no history of syphilis, rheumatism, gout, or tubercle.

About five years before admission he noticed a hard lump under and at the bottom of the left testicle. This was not accompanied with pain, nor were there any other notable symptoms, except a slight diminution of sexual desire. For the first two years the tumor very slowly grew larger; the increase in size was not accompanied with pain.

During the last two years its growth has been more rapid, and lately the patient has complained of frequent micturition, the desire to empty the bladder occurring about ten times a day.

On the 19th of March last the case was examined. What appeared to be the left testicle was very heavy, and its diameters measured twelve by eight inches. There was some fluctuation on the anterior and outer surface. A needle was introduced and a half ounce of straw-colored fluid drawn. An operation was then advised but was declined by patient.

On his admission to the hospital on December 3d the patient was examined and the following note made: T. 98½°. There is a large tumor occupying the left side of the scrotum, which measures fifteen and one-half inches from the groin to the bottom of the testicle and twenty-six and one-half inches in circumference at the largest part. The anterior surface of the tumor was fluctuating. There were no enlarged glands. Heart and lungs healthy; no hernia present. The general health appeared good. No enlarged glands could be made out in the groin or the pelvis, and it was assumed that we had to deal with a neoplasm of the testicle, probably of a benign character.

Operation was performed by Dr. Gerster December 5th, 1890. First the penis and right testicle were dissected out of the mass, together with an adequate portion of integument for their ultimate covering. A large number of

large vessels were encountered, each of these being secured between two artery forceps before being cut. Then the dissection was made very dry, though a large number of ligatures were required. When the first part of the operation was accomplished, the cord was exposed by a necessarily long incision extending from the symphysis to the anterior superior spine of the left side. This was unavoidable on account of the vastness of the attachment of the tumor and the depth of the cord, the latter circumstance being due to the fact that the skin of the groin, perineum, and thigh were drawn up to furnish part of the covering of the tumor. The cord being exposed was secured by a temporary elastic ligature, and now the tumor was excised, literally without any loss of blood. After ablation the vessels of the cord were tied separately, as in an amputation stump, and then the elastic ligature was cast off. Notable was the enormous hypertrophy of the cremasteric muscle. The skin flaps were now brought together by a large number of catgut sutures, and two drainage-tubes being placed in the angles of the wound, the parts were inclosed in an aseptic dressing. The tumor consisted of a solid mass imitating the form and character of a testis, an enormously thickened tunica vaginalis, which was distended by about two quarts of hydrocele fluid and hypertrophied scrotal integument, dartos, and masses of subcutaneous fat having the character of lipoma. The wound healed throughout by the first intention, the highest temperature noted being 99.6°. The drainage-tubes were withdrawn on December 8th.

Report of Examination of Tumor of Scrotum.—The tumor measured when received at the laboratory about 17 cm. by 22 cm. It was soft, translucent, and gelatinous in texture, showing here and there slightly denser areas due to delicate interlacing masses of connective-tissue fibres.

An occasional small blood-vessel was seen in the tumor mass. The whole was surrounded by a dense white connective-tissue capsule closely attached to but not continuous with the tunica vaginalis testis. The tumor thus appears to be wholly outside of the tunica vaginalis.

The testicle was found closely adherent to one side of the tumor, much flattened and distorted, but apparently intact, its vessels passing up wholly outside of the tumor. The exact origin of the tumor cannot now be made out owing to the great distortion and hyperplasia in the surrounding tissues, but it apparently is situated in the subcutaneous tissues between the corium and the tunica vaginalis testis.

The preliminary microscopical examination of the tumor shows that it is largely made up of a homogeneous or slightly granular and nearly everywhere sparsely fibrillated basement substance or stroma. In this stroma lie scattered and widely separated from one another, ovoidal, fusiform, and branching cells.

Small thin-walled blood-vessels are scantily distributed through the tumor.

The anatomical diagnosis is accordingly *fibro-myxoma of the scrotum.*

T. MITCHELL PRUDDEN.

DR. STURGIS read a paper on **The Diagnostic Value of Hematuria in Affections of the Genito-urinary Organs.**

The points offered for consideration were—

1. Whether the presence of blood in the urine presented any certain means for deciding which portion of the genito-urinary tract was diseased.

2. Whether blood-urine was necessarily a grave symptom.

As regards the first point, the reader argued that the rules laid down in the text-books were not of much value in deciding the source of the hemorrhage, inasmuch as the blood in severe affections of the bladder, of the prostate and kidneys, might be present at the same stage of urination as it is in simple inflammatory affections of the urethra, and that the character of the blood-clot does not furnish any means of deciding from which portion of the genito-urinary tract the bleeding originates. Furthermore, the cessation of the bleeding under the influence of rest or the administration of remedies does not help much toward arriving at an opinion of the source of the hemorrhage, for repose and medicines will arrest bleeding from the urethra or prostate as quickly as from the bladder and kidneys. The reader believed that the blood served the purpose only of calling attention to the presence of some affection of the urinary tract, but leaves the surgeon very much in the dark as to the source of the trouble, which must be sought for by other means. As to the second point, the reader did not believe that bloody urine was necessarily a grave symptom.

DR. KEYES thought that in certain cases the appearance of blood in the urine was a valuable factor in forming a diagnosis. He spoke briefly of the methods of ascertaining the seat of the hemorrhage, viz., by the use of the catheter with washing, the endoscope and cystoscope.

DR. W. K. OTIS called attention to the resorption test as a method of diagnosis, and insisted on the value of the cystoscope in determining the seat of the hemorrhage. He spoke of a case in which he had made the diagnosis of hemorrhage of the left kidney by this means.

DR. BROWN spoke of a case of hemorrhage in which no lesion was found on autopsy to explain its cause.

Chancres of the Fingers: their Clinical History, their Complicating Septic Infections, and their Danger in Surgical and Obstetrical Practice was the title of a paper read by DR. R. W. TAYLOR.

The author proposed the following divisions for the various forms of chancre of the fingers: 1, the scaling papule or tubercle; 2, the excoriated or exulcerated nodule or mass; 3, the fungating chancre; and 4, the psoriasis-like chancre. The clinical features of these forms of chancre were described at length. Attention was called to the fact that finger chancres were frequently complicated with lymphangitis and phlebitis, usually of a mild character, and attended with little, if any, systemic reaction. Three cases were reported in which pyæmia of a tolerably severe type and septicæmia were observed to complicate digital chancres. These complications were considered to be due to septic micro-organisms which were obtained from without.

The effects of chancres upon the fingers of surgeons, obstetricians, and mid-wives were fully considered, and the dangers of such lesions to their patients prominently pointed out.

Then the disastrous effects of chancres on the fingers of ignorant midwives were spoken of, and a personal case was mentioned in which one of these women was known to have infected one woman in child-bed, who in turn contaminated her husband and four children. It was probable that the syphilitic midwife had also infected other persons. The limitations of medical and legal surveillance over these women were spoken of.

The paper was discussed by Drs. Morrow, Sturgis, E. Fuller, Brown, and Gerster.

NEW YORK DERMATOLOGICAL SOCIETY.

203D REGULAR MEETING.

DR. E. B. BRONSON, *President, in the Chair.*

Case for Diagnosis.—Presented by DR. H. G. KLOTZ with the following history:

Anna Wolf, 2½ years of age, according to her father's report, has always been in good health, but although well nourished and heavy, shows some symptoms reminding of passed rickets. Since last February she has been affected with an eruption of the skin, which at different times has been more or less extended over the entire body, but is now principally confined to the lower extremities. It appears in the shape of numerous irregular dark red spots, which disappear on pressure. On some places they do not show any perceptible infiltration; at others are slightly elevated, without crusts or scales; while others bear on top a distinct vesicle or bulla, others a pustule or crust. The eruption causes considerable itching, particularly in the evening and at night. On some places smaller not so well defined, slightly elevated blotches would be seen, which seem to represent the early stage of development and which may well be classed as urticaria. The whole affection differed in several ways from the ordinary urticaria, principally by the persistence of the lesion.

DR. ALLEN considered the case one of ecthyma.

DR. FOX said the case differed from ecthyma in the absence of an inflammatory base and in the fact that the pus from the lesions in this case was autoinoculable. The vesico-pustules which occurred in connection with pediculosis capitis and corporis were of the same nature. He favored the term porrigo, used by Nayler, Hutchinson, and Startin, as preferable to impetigo contagiosa.

DR. BRONSON said that previous to the occurrence of contagion in cases similar to the one under discussion there was frequently a primary affection. In the present case he believed that urticaria was the original disease and the contagious element a secondary infection. He had seen urticaria with the formation of bullæ in which a subsequent contagion gave rise to a similar condition. Such cases were common among immigrants.

DR. FOX stated that this case differed from urticaria attended with purulent crusts in the fact that pus from the lesions in this child would prove to be auto-inoculable, while in urticaria it was not. He was confident that the lesions in Dr. Klotz's case were produced by a germ and conveyed over the body by infection in scratching. He referred to a case where a physician had inoculated his finger with a knife used in vaccination and produced a similar lesion.

DR. PIFFARD stated that he had described certain appearances seen under the microscope in the crusts of impetigo contagiosa and in the crusts of vaccination which he supposed to be spores. As far as he knew, no one had repeated his methods of examination.

DR. MORROW asked when the child had been vaccinated. The case impressed him as corresponding to Hutchinson's varicella prurigo. In the majority of such cases the eruption appeared soon after vaccination, and was very persistent.

DR. KLOTZ was inclined to the view advanced by Dr. Bronson, that the disease was primarily an urticaria and the pustules a secondary matter. The intense itching at night supported this opinion. He thought the lesions were too disseminated for ecthyma, which was generally limited in its extent and in its course.

DR. FOX suggested that Dr. Klotz try inoculation with the serum or pus from these lesions and also from a case of ecthyma. He would find the results very different.

DR. MORROW advised that the inoculation be made upon the skin of another person, as this child's skin was so susceptible that any irritation would probably cause such lesions to appear.

DR. FOX stated that all pus under certain conditions was inoculable; that the pus of acne might produce lesions upon other portions of the skin, but in no case would it produce the characteristic vesico-pustules of porrigo which would result from the inoculation of the pus in this case.

DR. POLLITZER (by invitation) said that Dr. Noyes, of Melbourne, and Dr. Pavloff, of St. Petersburg, working independently in different laboratories, had arrived at the same conclusion regarding the cause of the impetigo contagiosa of Tilbury Fox, viz., that it was produced by the staphylococcus pyogenes citreus, pure cultivations of the germ having produced the disease by inoculation.

DR. TAYLOR believed Bockhart had arrived at the same conclusion several years ago.

Psoriasis, or Eczema.—Presented by DR. FOX. The patient was a child with an abundance of scaly punctate lesions upon the trunk.

DR. JACKSON said that he had seen the case some days ago and had made the diagnosis of psoriasis. The child had not complained of itching, and there was no tendency to the formation of diffuse patches as in eczema.

DR. SHERWELL said that the discrete character of the eruption suggested psoriasis. He noted lesions like those on the body at the margin of the hair.

DR. FOX considered the case either as a psoriasis or a peculiar form of superficial eczema, of which he had seen a number of cases recently. He had photographs of several of these cases showing transition forms from pityriasis rosea to orbicular eczema. As a matter of prognosis it was important to determine the nature of the eruption in his case. If eczema, it could be readily cured; but if psoriasis, it would probably recur from time to time during the life-time of the individual. In punctate psoriasis there were apt to be a few guttate spots intermingled. In this case, however, the lesions were all punctate and had formed irregular patches, which was more characteristic of superficial eczema than of psoriasis.

Epithelioma of Penis.—Presented by DR. ALLEN to illustrate the results of treatment.

Timothy H., aged 34, single. Native of Ireland. Ten years ago had an operation for phimosis, which had existed from childhood. Was well then until four years ago, when an itching began on glans penis and a hard nodule made its appearance to one side of the meatus. No treatment was applied for a year, at the end of which time there was a wart-like, elevated, crusty, easily-bleeding, and extremely painful sore. This was burned a number of times under cocaine, but after each operation it would return and grow worse. Another physician applied acid for seven weeks without benefit. Patient then went to Bellevue Hospital, where an ointment was ordered. A surgeon

removed the growth with the knife twenty-one months ago. After this it healed up but never appeared well to the patient, and in course of time the warty growth appeared again. Grated-carrot poultices were then applied, followed by an ointment, but this treatment did not please patient, and he applied to me in June last.

There was then present on the under surface of the penis, involving the lips of the meatus and adjacent portions of the glans, the frænum and prepuce, a cancerous, warty tumor, the size of a five-cent piece in diameter, elevated above the surface, extremely tender and painful to the slightest touch, with marked hardness of the surrounding and deeper parts. Upon the left side was an isolated tumor of warty appearance, situated in the substance of the glans, equally sensitive. The smaller growth I scooped out with the curette and applied aristol, under which healing was prompt. Pyrogallol was applied to the larger growth in powder for ten days, when the growth had become even with the surrounding surface, showed less tendency to bleed, and was less painful, so that patient could resume work, which he had not been able to do for some time. During the summer patient continued using pyrogallol, which "kept the growth down," to use his expression, and enabled him to keep at work. On November 20th I applied the caustic paste recommended in this society by Dr. Lewis, and reapplied it two days later. It was somewhat painful and a deep slough followed. Under aristol powder the wound has cicatrized speedily and satisfactorily. There is still a deep-seated induration, which, however, is growing less since healing has taken place.

DR. TAYLOR had seen a great many cases of epithelioma of the penis and did not desire to question the diagnosis on such short examination, but the case did not impress him at all like one of epithelioma of the penis. In the first place, it was very unusual to see it in so young a man, and again, the glans was much less frequently attacked than the prepuce; when attacked the whole glans was very quickly involved in stony hardness and the meatus ballooned in, the inguinal ganglia were moderately enlarged, and he ventured the opinion that it was a syphilitic infiltration which had been cured by treatment.

DR. LEWIS was inclined to think that Dr. Allen's diagnosis was correct. The matter of age was subject to so many exceptions that one had no right to exclude the diagnosis on that account. The fact that the disease had been several times treated with strong caustics and recurred at the seat of removal would indicate cancer rather than syphilis. The cord-like condition of the body of the penis itself impressed him as if the organ was infiltrated with cancer tissue. Enlargement or non-enlargement of the inguinal glands would not influence his opinion, as he had often seen glandular enlargements disappear after amputation of the penis, showing that they were not the seat of cancer, but simply of irritation from the adjacent disease.

DR. KLOTZ remarked that frequently syphilitic new growths were not affected by general treatment, but required destruction by caustics or other local applications to cause their disappearance.

DR. ALLEN said that he had treated his patient by the internal use of antisyphilitic remedies and locally with mercurial plaster.

DR. KEYES was unwilling to express a final opinion, because the history was not that usually noted. He asked how long it had been since a cicatrix had formed.

DR. ALLEN replied that on the previous evening there was a spot of superficial ulceration about the size of a split pea.

DR. KEYES said that frequently in epithelioma of the penis the primary lesion was trifling and healed readily after one or another form of destructive treatment. He recalled two cases in which the primary trouble was completely healed, but in both of the cases the disease made its appearance in the groin without a return of the primary trouble. While he considered the local result obtained in Dr. Allen's case a good one, he thought the disease still present.

DR. TAYLOR added that the situation of the trouble in Dr. Allen's case suggested syphilis to him, because the late lesions of that disease have a tendency to develop about the meatus, the frænum, and in the urethra.

DR. FOX said that the few cases of epithelioma of the penis that he had seen were situated upon the glans rather than upon the prepuce and were not characterized by the stony hardness spoken of.

DR. ALLEN, in closing the discussion, said that an excised piece of the growth had been examined by Dr. Lustgarten and pronounced to be epithelioma.

Folliculite Décalvante.—Presented by DR. BRONSON, with the following history:

The patient, a young man 20 years of age, had suffered from disease of the scalp for ten years. It began as a small spot on the top of the head and gradually spread from this. When first the patient was admitted to the hospital the scalp was covered by thick, dark-colored, granulated crusts, and the appearance was that of an impetiginous eczema. On clearing off the surface the latter was found to be much cicatrized, and disseminated over the scalp were numerous small vesico-pustules, each of which was perforated by a hair. Further observation had shown that as these efflorescences disappeared they left permanent cicatrices. On the upper part of the forehead and temples were numerous small, flat, wart-like elevations.

DR. PIFFARD said that the case recalled to him the appearance of an old favus.

DR. MORROW thought the case under discussion corresponded very accurately to the description given by Quinquaud of folliculite décalvante. That writer had found a micro-organism in the hair follicles. Old cases of favus often presented much the same appearance, but Quinquaud had given such a definite and clear description of the disease that we must allow it possesses a distinct individuality. He thought it would be perfectly legitimate to class Dr. Bronson's case in the same category.

DR. ALLEN said he believed that it was an affection quite distinct from favus. He had seen a number of such cases and regarded it as a parasitic disease. He had found microscopic bodies in the affection upon the forehead which were similar to the molluscum bodies, though otherwise the appearances were those of verucca plana.

DR. POLLITZER (by invitation) said that the case corresponded to the model of Quinquaud's disease "Folliculite épilante," which he had seen in the Baretta Museum. The wart-like growths on the forehead he thought, from their grouping around the hair follicles, resembled an adenoma sebaceum, and corresponded to the tumors which were described by Pringle under that designation, though of course the diagnosis could only be made under the microscope.

DR. ALLEN had a dispensary service in the lower part of the city, where he saw a great number of Russian-Polish immigrants, among whom were cases of scalp disease similar to this one.

DR. BRONSON said in conclusion that the idea of his case being one of favus had of course occurred to him, but the microscopic examination failed to reveal the fungus of that disease. It was only after a preliminary treatment of some days by means of emollient applications to clean away the dried crusts from the scalp that the true nature of the affection became manifest. It seemed to be due to an inflammation of the hair follicles, and proved very rebellious to treatment. He did not think the previous existence of favus was quite excluded, though the patient gave no history of that disease. He had seen in immigrants, especially among the Polish Jews, a similar inflammation of the hair follicles, and was inclined to believe that in many of these cases favus had previously existed, but that another parasitic disease had supervened which was identical with the affection described by Quinquaud.

Late Serpiginous Syphilide (see cut).—Presented by DR. ALLEN. The patient was a young man who had been treated by Dr. Allen for syphilis about five years ago. The patient had disappeared before a thorough course had been given, and for several years had been in the West, wholly neglecting treatment. Extensive areas of tubercular syphilide, ulcerating, covered with thick crusts and extending in a serpiginous manner, now cover the trunk areas, forehead, and scalp. Patient has now entered the hospital and a thorough course of treatment will be followed out.

Dactylitis Tuberculosa.—DR. FORDYCE presented a photograph showing a fusiform swelling of the first phalangeal joint of the right ring finger. The patient, a boy, aged 8 years, presented no signs of acquired or hereditary syphilis. Two years ago the ring finger of the left hand had been amputated for a like condition. His present trouble has existed for over six months and has proved rebellious to anti-syphilitic remedies. Physical examination revealed a consolidation of the apex of the left lung.

Correspondence.

MOLLUSCUM BODIES AND POLARIZED LIGHT.

EDITOR JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

Sir:—In the last number of this JOURNAL Dr. Piffard opposes the theory of the parasitic nature of the structures described as coccidia in epithelioma, molluscum contagiosum, psorospermosis follicularis, Paget's disease, etc. He bases his argument mainly on the fact that molluscum bodies transmit polarized light like cornified epithelium in general, and from this observation declares that he "can arrive at but one conclusion, namely, that the so-called molluscum bodies or psorosperms, are not (so far as molluscum contagiosum is concerned) animal parasites, but are simply rete-cells undergoing a species of corneous degeneration," etc.

It seems to me that this is a very large deduction to base on a single observation. That molluscum bodies have some reactions in common with cornified epithelium is as old as the study of these peculiar bodies. Picric acid, for instance, stains both a bright yellow; but to argue identity of structure from similarity in reaction to a diffuse stain like picric acid would have been as unwarranted as the conclusion which Dr. Piffard bases on similarity in reaction to polarized light. In the form of a syllogism his argument is—

1. Molluscum bodies transmit polarized light.
2. Cornified epithelium transmits polarized light.

Therefore molluscum bodies are cornified epithelium!

The fallacy lies in what the logicians call the undistributed middle.

To give the argument force sufficient to warrant his conclusion, it would be necessary to show that cornified epithelium alone, and no other known structure, normal or pathological, transmits polarized light. It would be a simpler matter to establish a negative proposition. If Dr. Piffard had examined such well-known sporozoa as the coccidium oviforme of the liver of the rabbit as to their reaction under polarized light, he might perhaps have settled this question—or his own argument. If he will show us that these coccidia do not transmit polarized light while the molluscum bodies do, then the conclusion that molluscum bodies are not coccidia would be in some measure justified.

It must be admitted by every candid observer that the animal parasitic nature of the suspected cells in molluscum and other affections has not been established, and the demonstration will not be complete till successful inoculations have been made, or at least indisputable evidence of growth or reproduction in these cells furnished. But one fact has been established beyond a question: that, whatever else they may be, the molluscum bodies are not cells which have undergone corneous degeneration, Dr. Piffard's test to the contrary notwithstanding. By all their chemical relations, as Török and Tommasoli have shown, the contents of these peculiar cells seem to resemble—if a resemblance may be inferred from negative qualities—the substance known as colloid matter,—and is certainly not keratin.

Yours very truly,

21 WEST 52d STREET. S. POLLITZER.

Selections.

The Value of Atropia in Enuresis. R. BRUCE JAMES, M.D. (*Archives of Pediatrics*, Vol. VII., Sept., 1890.)

To test the favorable observations of Baruch and Watson, the author selected fifteen of the worst cases in the orphan asylum, and among whom no cause for the trouble could be made out. The ages of these patients ranged from three and one-half to nine years.

Some of them wet themselves alternate nights only, others every night, while a few suffered from diurnal as well as nocturnal enuresis.

In the asylum the small children are put to bed at 6 P.M. and made to rise at 9 P.M. and urged to urinate.

Each of the children was given one-hundredth of a grain of atropia sulphate at six and at nine. This dose was to be increased by the same quantity each night until a controlling dose was reached for each case.

None were benefited by less than four-hundredths of a grain given as stated, while others required as much as eight-hundredths of a grain.

The author states that nothing short of the quantity that produced full physiological effects was of any avail.

When the controlling dose was ascertained for each case it was repeated every night for one month, then altogether withheld. It was found that

many of the cases were completely relieved, while others were not benefited. The latter were again put under their controlling dose, which could neither "be tapered off" nor was it found necessary to gradually increase the original controlling dose.

Of the cases "completely relieved" the enuresis returned to all, with one exception, in periods ranging from one to six weeks.

The author, after giving histories in full, however, adds that since the long-continued use of atropia has no ill effect, nor tolerance established that requires an increased dose, and since the majority of cases can be so controlled by the drug, it is right to claim for the children and their mothers a valuable friend in atropia.

As to the children over twelve years of age who were put on this treatment, the author is unable to report a single case which was in the least benefited. F. TILDEN BROWN.

The Relation of Sexes. DR. C. DUSING. (*Internat. Centralbl. f. d. Physiol. und Patholog. der Harn- und Sexual-Organe*, Band ii., Heft 3 und 4.)

The relation of the number of males to the number of females born is a constant one as regards man, animals, and plants.

In man the numerical relation of male to female is 106 to 100. In horses, male and female, it is 100 to 98.

This relationship in man is subject to variation to a certain extent. For example, during war male births predominate. The absence of a considerable number of men exerts this certain influence. In favorable times not alone are a greater number of children born, but girls preponderate.

In unfavorable times fewer female children are born and more boys.

Among the first births in the human species there are relatively many males.

This excess is especially seen in the children of those mothers who are advanced in age when they become pregnant, and is attributable to the nutrition of the mother not being up to normal.

From the author's foregoing explanations, it is concluded that the sex is not inherited, but results from a combined action of causes. These factors act not only at the time of impregnation, but at various times after. From the beginning the ovule has a tendency to the development of a certain sex, and the semen possesses the same tendency; both combine at the time of impregnation to constitute one tendency, which determines the sex. Long after impregnation, when the embryo is already developed, the nutrition is still of influence, and can cause a change of tendency even if the sexual organs have begun to develop: as for example the occurrence in the mother of a poor state of nutrition may arrest the development of the female and bring about the development of male organs.

When this late reactionary influence remains absent or is not exerted strongly enough to cause a change in the development of the sexual organs, then the sex is definitely decided. F. TILDEN BROWN.

Hard Chancre of the Eustachian Tube. DR. B. T. SOLARI. (*Anales del Circuto Medico Argentino*, July, 1890.)

The writer describes a case of primary hard chancre of the Eustachian tube which presented itself in the practice of one of his *confrères*.

The patient, a prostitute, 32 years of age, applied for relief of a profuse purulent discharge from the nose and mouth, accompanied by deafness in the right ear. The suppuration had begun six days before and had preceded the deafness. There was pain on swallowing and on forcibly opening the mouth, localized in the faucial region and at the angle of the lower jaw. The mucous membrane of the pharyngeal cavity was somewhat reddened and inflamed, the posterior wall of the pharynx was covered with streaks of pus running down from above, and the breath was excessively fetid. Painless glandular enlargements were felt below the right angle of the lower jaw. The patient was in good general health excepting diarrhœa and stomachic disturbance, due, undoubtedly, to the pus swallowed during sleep. On examination the tympanic membrane was observed to be depressed in the centre. The Eustachian tube was sounded without pain, but the fibrous ring surrounding its orifice was found to be enlarged and indurated. Autoinoculations were made with a quantity of the pus taken from the nose of the patient, but they were negative. Later the breast, thighs, and legs of the patient were covered with a characteristic syphilitic roseola. Examination of the genitals and anal region was negative. After disappearance of the eruption, mucous patches developed on the internal surface of the lips and on the margins of the tongue.

Hygienic treatment, combined with syringing of the nasal cavity with liquor Van Swieten and a gargle of potassium chlorate, diminished the purulent discharge and induced the lesion to heal. Anti-syphilitic treatment was then rigorously instituted, and the disease brought under control. The deafness nevertheless did not completely give way. Cicatricial contraction of the orifice of the Eustachian tube still renders frequent sounding and insufflation of air necessary. PICK AND PRITCHARD.

A Case of Non-Tropical Chyluria. W. H. MYERS, M.D., Fort Wayne, Ind. (Read before the International Medical Congress, Aug., 1890.)

Patient æt. 27: female. Healthy until 11 years old, when she suffered pain of sciatic nature in the left thigh. At 16 a seton was passed in the upper portion of the thigh. A milky fluid escaped in considerable quantity. At this time the left was always larger than the right thigh, but varied at times in size, being augmented after active exercise. A number of rather large vesicles located upon the inner and outer aspects of the left thigh gave exit to a liquid—occasionally amounting to twelve ounces in twenty-four hours. Upon chemical analysis this liquid proved to be chyluria. Very recently, after a protracted illness the fluid from the vesicles ceased entirely, and since then chylous urine has been passed in large quantities daily.

Micturition being impeded at times owing to the presence of coagula formed in the bladder, the presence of a moderate quantity of blood gives a pinkish appearence to the semi-solid coagulum formed when the urine is set out in a vessel exposed to the air.

Urinary examination shows: Color milky; transparency greatly diminished; sp. gr. 1.020; reaction neutral; amount in 24 hours 3 to 4 pounds.

Chemical examination: Urine contains chyle in large amount; transparency of urine returns after shaking with anhydrous ether; the urine contains albumin, several grains to the litre, and a trace of urea.

Organized deposit consists of granules and some blood-corpuscles; no renal casts present.

Unorganized deposit: A few crystals of triple phosphate. The author adds that repeated microscopic examinations of the blood taken at selected times failed to detect the presence of filaria.

The author maintains that the evidence in this case refutes the renal theory of Ellison, Reid, and Rird, whereas Carter's belief that a fistulous tract communicates the renal system with distended lymphatics and lacteals of the lumbar region is directly supported. F. TILDEN BROWN.

Nephrorrhaphy. DR. WILLIAM W. KEEN. (*Annals of Surgery*, Vol. XII., No. 2, Aug., 1890.)

The theoretical distinction between movable and floating kidney—depending as it does upon the existence of a mesonephron in the latter—may in practice be overlooked. The range of mobility of the kidney, whether intra or extra peritoneal, whether congenital or acquired, may be equally great. The frequency of these cases has been underrated. The author shows that females furnish the vast majority of cases; and among all, the right side preponderates noticeably. The discomforts arising from movable kidney in both sexes are recognized as severe dragging pains, with a sense of weight in the loins. Gastric disturbances are common. Palpitation or other cardiac symptoms exist at times. In women disturbances of the generative organs is noticeable and that the majority of these women are of a highly neurotic constitution. In addition to suffering, these patients are not exempt from a fatal issue because of their floating kidney; hydro- and pyelo-nephrosis being the most common dangers.

The diagnosis of this kidney abnormality is pretty easily made if sought for. The careful examination of other organs to perfect exclusion is always proper.

The treatment is: 1. By bandage and pad; a conservative and successful means in certain cases. 2. Nephrotomy; only warrantable where symptons are grave and after other procedures have failed. 3. Nephrorrhaphy: done by exposing the kidney through an oblique incision reaching from the last rib to the crest of the ileum. At the outer border of the quadratus lumborum will be found the peri-nephritic fat, which when torn through exposes the kidney at once, unless the organ is still displaced despite its supposed reduction by the assistant's hand pressing on the abdomen. At this stage of the operation it is necessary to distinguish between liver and kidney, that the peritonial cavity be not needlessly invaded. The author suggests that to avoid this accident the operator should in every case, after tearing through the fat and reaching a firm organ, carefully observe its color. If the liver it will be of dark brown; if the kidney a lighter blue-black. The amount of traction with the volsella to bring the kidney into the wound is sometimes so great as to tear its substance; but harm does not follow.

For the final suture fixation four methods have been used:

1. Sutures passed through the adipose capsule alone.
2. Sutures passed through the fibrous capsule of the kidney itself.
3. Sutures passed through the parenchyma of the kidney.
4. The fibrous capsule may be stripped off the kidney to expose renal tissue, with the purpose of securing firmer adhesions. In this case the sutures are passed through the parenchyma and capsule just inside the border of the raw surface.

Whichever of these methods is followed, it is important that both extremities of the kidney should be fixed. The author ordinarily uses six sutures; one at both upper and lower and through both lips of the wound, penetrating through the kidney substance en route. Two other stitches are passed between one lip of the wound and the anterior part of the kidney.

Either kangaroo tendon, silk-worm gut, or aseptic boiled silk are the best for suture. The author prefers the last, and he uses it as fine as possible that they may be left permanently. The wound he believes is best treated as an open one, which retracts and closes with surprising rapidity. The management of the ilio-hypogastric nerve, crossed by the path of the incision, is best effected by an exsection of two or three inches.

The mortality of the operation is about two or three per cent.

The author appends a table of all the cases recorded up to date, besides full histories of four cases of his own—three females, one male. The results in all have been thoroughly satisfactory. F. TILDEN BROWN.

The Sublimated-Ether Spray in the Treatment of Small-pox Vesicles on the Face. DR. TALAMON. (*Gazetta medica Lombarda*, 1890.)

Discouraged by the negative results which he had obtained in the treatment of small-pox patients with numerous internal medications which have been recommended and employed successively by a large number of physicians, the writer confined himself exclusively to the external and local treatment of the pustules.

He tried spraying them with tannin, salol, iodoform, and sublimate solutions. The use of internal remedies being, up to now, unable to cope with the germ of variola, he thought that by means of local antiseptics he might be capable of acting upon the microbes of suppuration, which cause destruction of the derma, and by a convenient modification of Lister's procedure abort the greater portion of the pustule by keeping its surface under the influence of an antiseptic.

The tannin sprayings were made with a solution containing one gramme of tannin to ten grammes of a mixture of equal parts of alcohol, ether, and water. The tannin forms a varnish which compresses, flattens, and dries the pustules, but at the same time it also produces a tension of the face of extreme painfulness, and analogous to that following the application of collodion. The use of a fifty-per-cent ethereal solution of salol, sprayed on three or four times a day, calmed the pains, and was agreeable to the patient on account of the agreeable odor of the medicine. It was only found useful in the lighter forms of the disease. Its effects are nearly nothing in the coherent and confluent forms, where the suppurative inflammation of the derma is more deeply situated. Iodoform as a fifty-per-cent ethereal spray and used under the same conditions gave more satisfactory results than the salol, but less so than the use of the sublimate solution, but the disagreeable odor of iodoform rendered its employment offensive to the patient. The sublimate solution was prepared after the following formula:

Corrosive sublimate, ...	1 gm.
Tartaric acid, ...	1 gm.
Alcohol (90%), ...	5 c.cm.
Ether to make, ...	50 c.cm.

This was applied as a spray three or four times daily; its use should not be continued too long, for it may produce a painful vesication in the form of

long streaks. The individual's susceptibility to the irritant action of sublimate varies very much. In general, a spraying of one minute is sufficient in skilled hands: the skin is seen to become whitish in color, which change also extends to the pustule. This coloration is due to a deposit of sublimate, and is the result which the procedure should yield. When, however, the skin is covered by pustules scattered with long interspaces, salol may be employed in order to prevent the action of sublimate upon the points not covered by pustules. Contact with sublimate is well tolerated; patients only complain of a sensation of heat, which is accompanied by a redness of the skin, more or less vivid. The writer has never observed any signs of mercurialism, which seems to indicate that the mercury is not absorbed, but only acts on the superficial layers of the derma. During the procedure it is necessary to take the precaution to protect the eyes by covering them by layers of cotton dipped into a saturated boric-acid solution. The application of the sublimate spray does not completely prevent the formation of pits, but they remarkably diminish in number and depth. It is best to commence on the first day of the eruption, after a vigorous washing of the face with soap, which may be rinsed off with boric acid and dried with absorbent cotton. If one commence on the third day of the eruption the use of soap will then be unnecessary. After the spray has been used the face should be covered with a layer of a fifty-per-cent glycerolate of sublimate, in order to keep the skin continuously antiseptic and free from outside germs. After the fourth day only two sprayings are necessary, but the glycerolate should be applied the same. At the end of the sixth or on the seventh day the use of the spray may be left off and the glycerolate used alone. As soon as the crusts separate the glycerolate may be substituted for the sublimate-spray, in connection with borated vaselin or salol. Dr. Talamon combined, in the coherent, confluent, and grave forms of the disease, general sublimate-baths, prolonging their use for three-quarters of an hour to an hour; these, however, did not seem to have any well-marked action on the pustules situated upon the body. Still, those patients who were thus treated seemed to be less subject to the after-complications of convalescence so frequently seen. Finally, the buccal and pharyngeal eruption was treated by borated gargles and lotions.

This medication is absolutely powerless against the most severe forms—that is, the very confluent and hemorrhagic types.

Internally the therapy was limited to sustaining the strength of the patient by means of alcohol in doses of one hundred to two hundred and fifty grammes daily, according to the gravity of the case. The quantity of alcohol to be consumed by the patient is increased by addition of water up to one litre; this mixture may be given continuously in broken doses.

PICK AND PRITCHARD.

A Case of Retarded Constitutional Syphilis, not Transmitted to the Offspring. DR. RODOLFO STANZIALE. (*Rivista Clinica dell' Universita di Napoli*, No. 8, 1890.)

The patient was a woman, 27 years old and married. Her father is alive and in good health: her mother died of some ordinary disease. The patient could not tell whether her mother had ever aborted. She has only one brother, who enjoys good health. She does not remember having been sick during infancy. Fourteen years ago she began to suffer from a fetid nasal discharge accompanied, from time to time, by the coming away of

small pieces of necrosed bone, until, a few months afterward, the dorsum nasi was destroyed. The local trouble as well as the general condition improved very much under the administration of iodine. She was married four years ago, and a year after marriage she gave birth to a healthy child, which is still alive. After two other years she bore another child, which is now ten months old and came with her to the hospital, as it is still sucking: this child is also in an excellent physical condition and without any trace of syphilitic affection. It is about a year since which the affection from which she is suffering now made gradually its appearance.

Present State.—Deficiency of development of the body, especially atrophy and flaccidity of the muscles; subcutaneous fat nearly wanting; earthy-pale skin, which can be lifted up in large folds. A tumefaction is noticed on each frontal eminence, that on the left side being a little larger than that on the right, having the size of a small hen's egg. They are both regular in outline, well circumscribed, painless, immovable, soft, and somewhat fluctuating.

On the surface of the left labium majus is noticed an ulceration of the size of a cent-piece, with a well-defined edge, a lardaceous base, and purulent secretion. Ulcerous lesions having the same characteristics as the above were found in the superior portion of the pharynx, at the soft palate, with destruction of the uvula. There were also perforation and partial destruction of the hard palate. The nose was flattened in its entire length, except the alæ, assuming the shape of a "saddle nose." The inguinal and latero-cervical lymphatic glands were multiple, small, atrophied, movable, painless, almond-shaped, and of a duro-elastic resistance. The epitrochlear ganglia were not perceptible. In the left submaxillary region there was observed a tumefied gland of the size of a hazel-nut, which was movable, painless, hard, and with unruptured skin.

Treatment.—Inunctions with mercurial unguent; iodide of potassium in increased doses; mercurialized gauze applied to the tumefactions on the forehead; application of lotions of a sublimate solution and iodoform-glycerole to the ulcer of the left labium majus; and spraying of the ulcers of the palate with Van Swieten's solution. The ulcers of the palate were also touched with a solution (1 : 20) of nitrate of mercury.

This treatment, continued for three months, was followed by considerable improvement.

This case contributes to show that syphilis is not hereditarily transmissible in the tertiary state.

The author further states that to Ricord belongs the merit of having directed the attention of syphilographers to this fact. He has observed this also in other cases, and thinks that Ricord's statement, therefore, has the value of being a pathological fact. PICK AND PRITCHARD.

Sulphur in Variola. DR. JACINTO ISCAR. (*El Siglo Medico*, 1890, p. 219.)

The writer, knowing the efficacy of sulphur as a remedy in those diseases which localize themselves upon the skin and mucous membranes, tried it in several cases of variola with success. It was first given to a female patient brought to the hospital, in whom, after twenty-four hours of this treatment, the dark, lead-colored, and almost cyanotic color of the skin not covered by the pustules was changed, diminished, and converted into red, while

the general symptoms lost much of their former severity. During the treatment the skin acquired its normal coloration, the general symptoms were much ameliorated, and the patient passed through an uneventful convalescence to recovery. Several other cases are also cited, some of them extremely grave, in which the sulphur treatment was also instituted, with good results in all cases but one, that of a child several months old, which died.

This method of treatment has a favorable influence upon the suppuration, and indeed, if it be instituted at the beginning of the eruption it will be better controlled than if initiated later. The writer used the following formulæ :

1. Sublimated sulphur, ... 1. gm.
   Pure glycerin, ... 0.50 gm.

Mix.—Sufficient for one wafer. The number of wafers to be given in twenty-four hours varies according to the gravity of the case and the intensity of the symptoms. The writer ordered one wafer given hourly to adults, as the remedy was well borne and there was no gastric intolerance.

2. Sublimated sulphur, ... 10 gm.
   Pure glycerin,
   Orange-flower water, ... āā 60 gm.
   Simple syrup, ... 30 gm.

Mix.—This formula was used in children's cases and in a case with dysphagia where the symptoms were not of extreme gravity.

Dose : A teaspoonful hourly for children ; a tablespoonful each hour for adults.

3. Sublimated sulphur, ... 40 gm.
   Glycerin, ... 150 gm.
   Orange-flower water, ... 50 gm.
   Simple syrup, ... 60 gm.

Mix.—A tablespoonful every hour for adults ; every two hours for children.

This formula was employed in the gravest cases. PICK AND PRITCHARD.

Book Reviews.

Dei Morbi Sifilitici e Venerei. By ROBERTO CAMPANA, Professore ordinario di Clinica Dermosifilopatica nella regia Universita di Genova. Genova, 1889.

This work of an Italian master in his specialty comprises two parts bound in one volume of 522 pages. The first and more important part is made up of seventeen chapters upon syphilis and syphilitic affections ; the second treats of other venereal diseases in fifteen lectures or *Conferenza.* The whole subject is presented in an attractive form, and the numerous complications and rare manifestations of disease are carefully worked up. The chapters are so subdivided that reference is made easy, and further aid is given by an alphabetical index which completes the volume. The chapters on

syphilis, beginning with the definition of the disease, follow through the various stages, discuss the implication of the different organs and tissues of the body, and complete part first, with two lectures devoted to the general and local treatment.

At the end of each chapter are a number of pages devoted to clinical observations which serve to illustrate features of the text. There is one chromolithograph illustrating the gonococcus, etc., and a number of wood-cuts which are not suggestive of high Italian art. One, however, of a case of hypertrophic and deforming cicatrix of the face, neck, and chest, shows a remarkable result of syphilitic ulceration. Observations upon lymphadenitis gummosa, myocarditis gummosa, and other unusual conditions are of considerable interest.

The orthography of proper names is not always accurate, but it is probably only by a printer's error that we find "Beumstead" and "Luesgarten" spoken of. The work, which is evidently intended as a handbook for students and practitioners, will be of interest as showing the modern teachings of the Italian school. C. W. A.

Ointments and Oleates, Especially in Diseases of the Skin. By JOHN V. SHOEMAKER, A.M., M.D., Prof. of Materia Medica, Pharmocology, Therapeutics and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia, etc., etc. Second edition, revised and enlarged. Philadelphia and London: F. A. Davis, publisher. 1890.

THE first edition of Dr. Shoemaker's book on "The Oleates" was favorably noticed in this JOURNAL upon its first appearance in 1885. In the second edition, now before us, the scope of the work has been extended so as to embrace a consideration of ointments. The value of the book has, we think, been materially enhanced by this addition. Undoubtedly ointments constitute the most universally applicable and efficient means at our command in the local treatment of many forms of skin disease, and this conspectus of our knowledge of anything relating to inunction cannot fail to prove valuable as a work of reference.

The different substances used as bases for ointment in the local medication of diseases of the skin are first considered. Quite a subordinate importance is assigned to vaselin and other petroleum products, the author regarding them as inferior and objectionable on account of their irritating action and their unabsorbent properties, a view in which, it may be said, the majority of experienced dermatologists do not concur. He then gives a compilation derived from all accessible sources of the officinal ointments as well as those in common use in this country, together with a list of the officinal ointments of the Pharmacopœias of Great Britain, France, Germany, Austria, Italy, Spain, and Mexico. This compilation is exceedingly interesting, although many of the combinations possess only a historical interest, as they must be considered crude and unscientific in the present advanced position of modern pharmacy.

Dr. Shoemaker is still an enthusiastic advocate of the oleates for local medication. He claims that the value of these preparations has been enhanced by the very marked improvement in the quality of oleic acid and its salts and in improved modes of preparation, some of which have been incorporated in this edition.

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Original Communications.

THE CONTAGIOUSNESS OF CHRONIC URETHRAL DISCHARGES.[1]

BY GEORGE EMERSON BREWER, M.D.,
New York.

THE practising physician is frequently called upon to answer inquiries regarding the limit of the contagious stage of a gonorrhœal urethritis.

The question is a serious one, especially when considered in its relation to marriage, and should, I believe, be regarded as equal in importance to that of syphilis.

It has not infrequently been my experience to be consulted by young men, a few weeks or months before a contemplated marriage, with a history of one or more attacks of gonorrhœa in former years, and who believe themselves to be well; yet who upon a careful examination present the unmistakable signs of a chronic urethritis.

The only evidence of disease remaining in these cases may be and frequently is the presence in the urine of small thread-like bodies, to which the name of *tripper faden* has been given by the German surgeons who first described them and demonstrated their importance. These minute shreds are composed of mucus, pus, and epithelium; and represent the secretions which adhere to any granular patch or area of chronic inflammation remaining on the urethral mucous membrane.

As these cases have often caused me no small measure of anxiety, it is the object of this communication to call attention to the opinions of some of our most prominent authorities upon the subject, and to

[1] Read before the Section on Genito-Urinary Surgery, New York Academy of Medicine, Thursday evening, Feb. 12th, 1891.

elicit the views of those present whose experience has been greater than my own.

In consulting the standard authors upon the subject of genito-urinary diseases, one is impressed by the marked difference of opinion, regarding the contagiousness of chronic urethral discharges, held by those whose reputation and experience entitle them to the foremost position in the discussion of this question.

As early as 1785 Kühn called attention to the fact that the discharges resulting from a gonorrhœa remained contagious so long as they contained pus. The opposite opinion was held by Hunter who denied the possibility of contagion from the gleety discharges of a chronic urethritis. This view was also shared by Bell and Ricord. In a paper entitled "Gonorrhœa a Non-specific Disease," published in the *New York Medical Independent* in 1864, A. K. Gardiner strenuously denies the contagious element in any, save the discharges from the most acute stage of the disease; and says regarding gleet that it is "allowably benign and innocuous."

Noeggerath on the other hand, in a paper published in 1872,[2] concludes that a man who has once been the subject of a gonorrhœal urethritis, *never* fully recovers, that the disease invariably lingers in the glands and ducts emptying into the canal, and may at any time furnish a secretion which may infect those with whom he has sexual relations. He also states that nine-tenths of all women married to men who have had gonorrhœa, sooner or later become the subject of incurable and painful inflammatory disease of the uterus, tubes, or ovaries; that this infection may take place rapidly, and manifest itself as an acute affection, or by means of a slow and unrecognized process to which he gives the name of "latent gonorrhœa." In a subsequent paper, read before the American Gynæcological Association in 1876, the author reiterates these opinions, and adds that 90% of all cases of sterility can be directly traced to gonorrhœa.

Without entering into any discussion regarding the correctness of these views, which have been the object of considerable criticism, the fact remains that these papers had the effect of calling attention to a source of female disease and suffering, the importance of which had not, until their publication, been adequately recognized.

This difference of opinion upon so important a question is hardly to be wondered at, when we consider that at the time these views were enunciated, nothing definite was known regarding the etiology of this disease.

Since the discovery by Neisser in 1878 of the gonococcus, and the establishment of its relationship to this disease, but one opinion can

[2] "Die Latente Gonorrhoe im Weiblichen Geschlecht," Bonn, 1872.

logically be held by those who accept his theory of gonorrhœal inflammations, and that is, that all secretions containing this micro-organism are capable of transmitting the disease under favorable conditions. In his recently published work [3] upon this subject, Ernest Finger emphasizes this point and states regarding marriage, that it should be absolutely prohibited in all cases where the existence of a chronic urethritis is evidenced by the presence of the "morning drop" or *tripper faden* in the urine, until the following facts have been established:

1st. That after from two to four weeks of daily observation, the secretions from the urethra are found to be *free from pus and made up wholly of epithelial cells.*

2d. That no gonococci can be detected by the microscope, even after a purulent discharge has been established by the employment of irritating injections of corrosive sublimate or nitrate of silver; and

3d. That neither prostatitis nor stricture exists.

I must confess that upon first becoming acquainted with the views expressed by this author, I regarded his conditions unnecessarily severe, and his opinion of the danger greatly exaggerated. A somewhat remarkable case, however, soon came under my observation which illustrated in a most striking manner the fact, that unless some of the precautions advised by Finger had been insisted upon, the responsibility of a terrible and dangerous illness would justly have rested upon my head.

Mr. H., aged 30, called on me in October, 1889, and stated that he expected to be married in six weeks, and that although he knew himself to be perfectly well, he desired the confirmatory assurance of a physician after a thorough examination. He told me that, six years ago, he had experienced an attack of urethritis which was unusually acute and severe, and which continued uninterruptedly for a period of more than twelve months. After nearly a year of unsuccessful treatment, he submitted to a circumcision and meatotomy in the hope that the improved condition of the parts might favor a more rapid recovery.

At the end of a very tedious course of treatment the discharge ceased, and with the exception of one or two slight exacerbations after alcoholic or sexual excesses, he has since remained free from the evidences of an active urethritis. For the past three years, he alleged, there had been absolutely no urethral discharge save at times a slight moisture at the meatus in the morning.

Upon examination no secretion could be pressed from the urethra. Exploration by means of the urethrameter revealed a normal calibre of 36 F.—meatus 28—a stricture measuring 30 at 3 inches. Endo-

[3] "Die Blennorrhöe der Sexualorgane und ihre Complicationen," 1888.

scopic examination showed granular patches and congested areas in the neighborhood of the bulb and behind the stricture.

An examination of the urine revealed, in the first portion passed, a number of *tripper faden*. One of these was selected, spread out upon a slide, stained, examined microscopically, and found to contain epithelial cells, pus, and several very characteristic colonies of gonococci.

At the conclusion of the examination he was told that it would be impossible for him to think of being married at the time stated, or at any subsequent date, until he had been relieved of his chronic urethritis, and until examinations of the urethral secretions failed to demonstrate the presence of gonococci. Upon the receipt of this advice he became somewhat indignant, affirmed that "he knew better," and that repeated experience had taught him that there was nothing contagious remaining in his urethra. I immediately called upon Dr. Holbrook Curtis who was in an adjoining room, to confirm the microscopic diagnosis and bear witness to what was said, and I again repeated in his presence my former statement and added that as his medical adviser I absolutely forbade the marriage, and that if he declined to accept my advice, he must assume the entire responsibility.

Without dwelling upon the details of several interviews which followed, suffice it to say that he reluctantly promised to postpone the ceremony and undergo a proper course of treatment.

The strictures were divided and the subsequent treatment consisted in the passage of full-sized sounds, urethral irrigation, and local applications by means of the endoscope. He slowly but steadily improved, and at the end of five weeks the *tripper faden* had markedly decreased in numbers; gonococci could, however, occasionally be found. At no time was there any discharge from the urethra.

At this period he suddenly announced that it was his intention to carry out his original plan and be married in a week—which he did against my advice and assuming all responsibility.

The sequel to this narrative is peculiarly sad and instructive.

Two weeks after the ceremony I was called to attend his young wife, who presented all the symptoms of a severe gonorrhœal infection. Examination revealed the presence of an angry and painfully acute purulent urethritis and vulvitis, pus from the urethra showing abundant colonies of gonoco ci. A severe cystitis followed, a large vulvovaginal abscess which was opened under ether, also a marked pyelitis which continued for many months. The patient was in bed under the constant watchfulness of a trained nurse for seven weeks, and during the year which followed was more or less of an invalid, suffering from recurrent attacks of cystitis, and all directly traceable to the unfortunately premature marriage.

I am aware that extraordinary and seemingly remarkable cases of this kind frequently admit of a more simple and rational explanation when all the facts are accessible, and that the discovery of another and more recent source of infection often dispels illusions and destroys theories which have been reared upon the insufficient evidence of a few imperfectly investigated cases. In this case, however, I was in a position to become familiar with all the circumstances, and having a professional acquaintance with both patients and their families for several years, I can state without the slightest hesitation that the possibility of an infection in a manner other than I have indicated is wholly out of the question.

In reviewing the records of nearly one thousand cases of urethritis treated by me during the past five years, I find that in six instances I was consulted regarding the propriety of marriage, under circumstances similar to those which existed in the case reported above. My rule had always been in such cases never to allow marriage until at least three months had elapsed since the cessation of all acute symptoms, and until repeated examinations of the secretions (including the *tripper faden*) had failed to show the presence of gonococci. In the six cases referred to, these conditions were observed—and in no instance has the wife exhibited the slightest evidence of infection.

It is to me somewhat surprising that, in most of the recent works on this disease, little or no attention is given to this very important subject, whereas the question of syphilis and marriage has occupied the attention of a very large number of writers. I think I am justified in saying that it is the opinion of those acquainted with the subject, that far more suffering and incurable disease in women can be attributed to gonorrhœal than to syphilitic infection.

In conclusion allow me to urge upon all interested in this subject the necessity of unusual care in examinations undertaken with a view to forming an opinion regarding the propriety of marriage, in those who have been the subject of gonorrhœal urethritis. The safest method would be to follow the advice of Finger as quoted above; certainly none should assume the responsibility of sanctioning a marriage without at least imposing the conditions which it has been my custom to insist upon, before I became acquainted with the views of this distinguished authority.

118 Madison Ave.

REPORT OF A CASE OF PAPILLARY ADENO-CARCINOMA OF THE BLADDER REMOVED BY SUPRA-PUBIC CYSTOTOMY, WITH SOME OBSERVATIONS UPON THE DIAGNOSIS OF SMALL PAPILLARY FIBROMA OF THE BLADDER.[1]

BY SAMUEL ALEXANDER, A.M., M.D.,

Professor of Genito-urinary Surgery, etc., in the Bellevue Hospital Medical College; Surgeon to Bellevue Hospital.

HENRY H., aged 39 years, a mulatto, native of the United States, was admitted to Ward 15, Bellevue Hospital, January 13th, 1891.

History.—The patient states that his father died of pneumonia; that his mother, now 59 years of age, is alive and in good health; that two sisters died from causes which he does not know; and that he has a brother living and well.

He says that he has had "gravel" since childhood, and that since 1868 he has been operated upon for stone in the bladder four times. The first operation was performed by a Dr. Smith, U. S. Army, and the last about five years ago by my colleague, Dr. F. S. Dennis. All the operations were perineal lithotomies.

The symptoms of which he now complains began between two and three years ago, and he says were at first similar in some respects to those which had accompanied his "attacks of stone." He first noticed a scalding sensation in the urethra during the act of micturition, and a frequent desire to urinate both by day and night. At first he had no pain, but as his symptoms increased in severity he began to suffer from pain, especially at the close of micturition, which was referred to the end of the penis; he had also a feeling of weight in the perineum, and backache. Sometimes his urine was bloody, the color, he says, being a bright red; then again it would be free from blood, but there were usually a few drops of bright blood passed at the end of the stream. The attacks of bleeding occurred without any assignable cause. As the frequency of urination increased the urine became turbid, and on standing deposited a thick sediment resembling flour-paste.

On his admission to the hospital he appeared thin and pale. He was obliged to pass water every half-hour night and day. The urine passed was free from blood, and he states that it has been several days since the last hemorrhage. The urine was examined with the follow-

[1] Read before the Genito-urinary Section, New York Academy of Medicine, Feb. 12th, 1891.

ing result: Sp. gr., 1024. Color, yellow, turbid. Reaction, acid; sediment thick, yellowish-white, no sugar, no albumin. Microscopical examination: pus-cells in abundance, a few blood-cells in each field, bladder epithelium from upper strata, no crystals, no morbid tissue.

On the day of his admission I made an examination with the following result.

The patient was placed on the operating-table and his urine was drawn by an English silk catheter, No. 22 F. It was of a dirty yellow color, turbid, and contained some flakes of muco-pus, but no blood. The bladder was gently distended with a hot saturated solution of borax. Its tension capacity was between two and three ounces. Four ounces of fluid were then injected, and as it returned through the catheter it was slightly tinged with blood. A Thompson's searcher was introduced and the bladder was examined for calculus; none was found. The contact sensibility of the bladder was everywhere slightly increased. At a point on the posterior wall a small elevation was detected, which, upon being touched by the searcher, caused the patient to cry out with pain. The searcher was passed over this point several times, and this caused a sharp hemorrhage of bright blood. The prostate by rectal touch was found smaller than common, and was slightly irregular in outline—probably owing to the former operations for stone. A diagnosis of probable papilloma was made, and an operation for its removal was offered to the patient and accepted by him.

On January 15th I performed a supra-pubic cystotomy, assisted by the house surgeon, Dr. Banks, and in the presence of the house staff of the hospital. The rectum was distended by Petersen's colpurateur, ten ounces of fluid being used, and six ounces of fluid was injected into the bladder. During the operation, and just before opening the bladder, I wounded the peritoneum owing to its abnormally low attachment to the bladder. The wound was about half an inch in length. I closed it with a continuous suture of fine catgut, and during the remainder of the operation it was covered by a flat sponge and gave no trouble. After the bladder had been opened and its cavity sponged out an examination was made. The walls of the bladder were not thickened. The mucous membrane was everywhere the seat of a moderate chronic inflammation. The orifices of the ureters and of the urethra were free. Upon the posterior wall of the bladder, a little to the left of the median line and about two inches above the trigone, there were three small, gelatinous-looking papillary elevations. The largest was about an inch in length by half an inch in width, and projected about a quarter of an inch above the mucous membrane. The others were about the size and shape of a pea, and were situated about half an inch apart. The three growths

were reddish in color, they were soft, and bled profusely when touched with the sponges. The mucous membrane about them was congested, but the bladder wall did not seem to be thickened. These growths were entirely free from villi. Nothing further abnormal could be detected either by inspection or palpation. The three growths were easily removed with a sharp curette, and their bases were thoroughly scraped. The hemorrhage was very profuse, but was easily controlled by the use of hot water. A perineal opening was made into the membraneous urethra, and a large red rubber catheter, 33 F, was introduced through it into the bladder and secured in the usual way with tapes to a waist-band.

The bladder was closed by a continuous suture of catgut, and the surfaces of the abdominal wound were brought together by heavy silk sutures carried deeply through all the tissues. No drainage-tube was used in the upper wound. A heavy compound dressing was applied and secured by a broad binder, firm pressure being thus brought upon the wound. The patient was given a full dose of morphia and put to bed.

There was very little hemorrhage from the bladder after the operation. The perineal tube was retained for ten days, being removed daily and cleaned. The bladder was washed twice daily with a solution of borax. The supra-pubic wound united by primary union. The patient since the operation has had no rise in temperature above 99° F., and has been very comfortable. On January 27th all urine passed through the urethra.

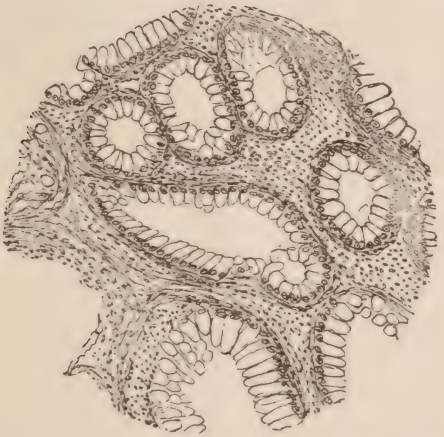
The following note was made on January 28th: Patient has good appetite and feels well. He still passes water too frequently, and has some burning in the urethra during micturition. He is entirely free from pain, and has no hemorrhage from the bladder. The urine still contains some pus, but is much clearer than before the operation. The supra-pubic wound is entirely healed by primary union.

On February 3d I examined the patient, as the desire to urinate continued to be too frequent. I found that the bladder did not yet empty itself, there being about ʒ ij. of residual urine. I directed the patient to use a catheter twice a day, and this has relieved the frequency in a great measure. At the present time, exactly one month since the operation, the patient is up and about. His urine still continues to have a little pus in it, but otherwise it is normal, and there is some burning in the urethra during urination. He is, however, wholly free from pain, and now retains his urine for five and six hours.

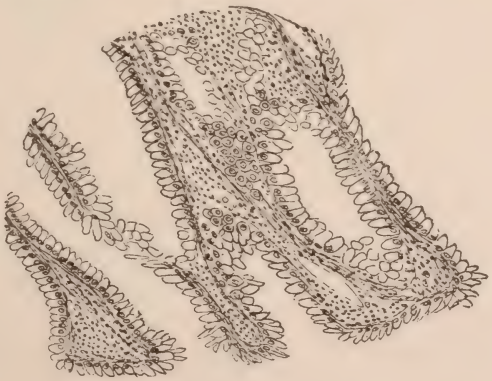
The largest of the growths removed from the bladder was sent to Dr. Herman Biggs, of the Carnegie Laboratory, who reports as follows:

"The mass of tissue received for examination was small and had been in alcohol, so that no idea of the macroscopical appearance could be formed. Sections from it revealed the following structure:

"There are tubular or irregularly-formed cavities located in a rather



richly nucleated connective-tissue stroma, and these cavities are lined by a single layer of tall cylindrical epithelium. The surface of the growth presents simple papillary tufts covered over by cylindrical epithelium similar to that lining the spaces. The growth has extended into the muscular wall of the bladder at some points, and where this has occurred the cavities are situated in a stroma made up of smooth muscle-fibre mingled with fibrous connective tissue.



"These growths are rare in this situation. They closely resemble the so-called malignant adenomata which develop from surfaces normally covered by cylindrical epithelium, as the stomach, intestines, uterus, etc.

"They differ from the simple papillary growths of the bladder in their clinical history and their anatomical structure.

"The simple papillary growths are benign clinically, while these growths are commonly malignant; the former are purely surface growths and the papillary form is characteristic, while in the latter the papillary surface growth is rather an accident, the characteristic structure being shown in the deeper portions or where the growth has extended into the underlying tissues.

"Such tumors are best denominated papillary adeno-carcinoma, or cylindrical-celled epithelioma. The former term, adeno-carcinoma, perhaps best describes both their anatomical and clinical characteristics. The occurrence of growths made up of cylindrical epithelium in the fundus of the bladder is not easy to explain. It perhaps must be assumed that they arise from the mucous glands or their ducts, which are sparsely scattered through the mucous membrane here."

Notwithstanding the great progress that has been made, especially in the last decade, in our knowledge of the pathology and clinical behavior of vesical tumors, there is yet considerable confusion in regard to the proper classification of some of these growths, and especially in regard to the malignancy or non-malignancy of many of the so-called papilloma.

Simple non-malignant papillary growths are the commonest of all vesical tumors, while malignant papillomata are comparatively rare.[1] Some writers deny the existence of the latter, and Sir Henry Thompson does not mention them in his classification of tumors of the bladder.[2] Orth,[3] in his recently-published text-book upon special pathology, describes two principal forms of papillary growth (Zottengeschwülste) in the bladder, viz., simple papillary fibroma (papilläre Fibrome) and papillary cancer (papilläre Krebse). The former includes the simple villous, and simple fibrous papillomata. These are purely superficial growths and are non-malignant. The papillary carcinoma (papilläre Krebse) differ from these in their structure, and they involve the deeper structures of the bladder. They cannot, however, be distinguished macroscopically from the simple papilloma, except in cases in which the walls of the bladder are thickened and infiltrated. Superficially they resemble the non-malignant papillomata. A differential diagnosis between simple non-malignant papillary fibroma and papil-

[1] Sperling: "Zur Statistik der prim. Tumoren der Harnblase," Berlin, 1883. In 120 tumors of the bladder there were 42 simple papillomata and only 19 medullary carcinomata and papillary carcinomata.

[2] Brit. Med. Jour., Jan. 9th, 1890.

[3] Orth: "Lehrb. der Spec. Path. Anat.," 4 Lieferung, ii. Band, 1 Lieferung, p. 214 et seq.

lary cancer can only be made by microscopical examination of the deeper portion of the growth or of the bladder wall itself.

Orth [4] states that the simple form may become malignant and involve the deeper structures of the bladder, an important fact as bearing upon the necessity of early operation in cases of this kind.

It is certain that the simple forms of papilloma may co-exist with the malignant. A superficial growth having the characteristics of a simple papilloma may be associated with a carcinomatous deposit in the deeper portions of the bladder wall.

On June 2d, 1888, I operated in Bellevue Hospital upon a patient for multiple papillomata of the bladder. Supra-pubic cystotomy was performed. The bladder walls were greatly thickened, especially in the region of the trigone. A number of small fibrous papillary growths were removed with a sharp curette and submitted to microscopical examination. They showed merely the characteristics of a simple papilloma. The symptoms of pain and hemorrhage which had existed for about nine or ten months before the operation were not relieved by the operation. The patient, while he recovered from the effects of the operation, continued to lose flesh and strength and died two months later, from exhaustion. No autopsy could be obtained, but it is more than probable that in this case the bladder was the seat of a carcinomatous deposit, associated with superficial non-malignant papillary outgrowths.

Dr. Reliquet [5] reports the case of a man 60 years of age, of a cancerous family, who suffered from attacks of painful micturition and hæmaturia for four months before his death. The autopsy revealed a "diffuse villous carcinoma." The mucous membrane was pale, but showed no evidence of disease either to the eye or touch. On filling the bladder with water, however, there was seen about the neck of the bladder, over the trigone, and upon the anterior, lateral, and posterior walls, a veritable carpet of very small villosities, one-half centimetre in length, and three larger villous tufts near its periphery. Microscopical examination by Cornil showed the bladder walls, especially the muscular coat, infiltrated by a carcinomatous growth.

Like the simple papillomata, papillary carcinomata are usually found in the region of the trigone and near the ureteral orifices and internal urethral orifice. They may be single or multiple, small or large. They usually involve the muscular wall of the bladder, and microscopically show an adenomatous or true carcinomatous structure. A single case of papillary adenoma, of the bladder, non-malignant, has been reported by Kaltenbach.[6]

[4] Loc. cit., p. 216.

[5] Annales des Mal. des Organ. Genito-urin., vol. 4, p. 180, 1886.

[6] Arch. f. klin. Chir., 30, p. 659, 1884.

From what has been said above, it will appear that the growth removed from the case which I have reported is peculiar, both on account of its superficial character and structure, and especially from its situation upon the posterior wall of the fundus of the bladder.

Reports of papillary carcinoma in which the histological structure of the growth is described in detail are few, and I have as yet been unable to find any case reported which is similar in structure and position to that given above. Until more cases of this variety are reported, it will be impossible to form a positive opinion in regard to the prognosis of these growths.

It would require too much space to do more than mention the relation which is said to exist between vesical calculus and the production of vesical cancer. It is sufficient to merely call attention to the prolonged irritation in this case from calculus and the subsequent development of papillary carcinoma as a possible relation of cause and effect.

The diagnosis of small papillary tumors of the bladder is a subject of great importance. When the growth belongs to the villous or fimbriated variety, the microscopical examination of the urine may reveal their existence. In the case of a fibrous papilloma, however, the urine shows but little that is absolutely distinctive. In these cases the cystoscope is of great value in certain cases. If the growth is small, however, it requires great familiarity and experience with the instrument to see it, and when the growths are multiple they may be mistaken for enlarged folds of mucous membrane.

I have now seen six cases of small multiple fibrous papillomata of the bladder. Four of these cases were operated upon by me at Bellevue Hospital; the others were seen in consultation in private practice. In all of these cases I have observed a sign which, when taken with the history of the case, is of considerable diagnostic value. I refer to the exquisite sensibility of these growths to the contact of instruments, and their tendency to bleed freely when an instrument is rubbed over their surface. When a case presents itself with a history pointing toward the existence of a vesical growth in which there are one or more points of great tenderness in the bladder, and these points when rubbed over by the searcher yield a free hemorrhage, papilloma may be reasonably suspected to exist. In all of the cases I have seen this has been a constant sign. It is hardly necessary to mention here the value of digital exploration through the perineum in all cases of doubt. The operation is so simple and so almost entirely devoid of risk that I believe it should be resorted to in all cases of doubt before performing the supra-pubic operation. The perineal opening does not interfere with the latter operation, as the rectal colpurateur when dis-

tended prevents the escape of fluid from the bladder by its pressure against the membranous portion of the urethra.

In closing this article I desire to add a word concerning immediate closure of the bladder and perineal drainage after supra-pubic cystotomy, as the subject is now so generally under discussion. My personal experience is in favor of this method, except in the following conditions, viz.: 1. In cases in which the walls of the bladder are greatly thickened or diseased. 2. When the hemorrhage is likely to continue after the operation. 3. When the internal urethral orifice or the prostate are the seat of malignant disease. In these conditions I prefer to drain the bladder from above as suggested by Périer.

When the bladder is immediately closed and perineal drainage employed, I believe that success depends very largely upon attention to three points. These are: 1. The manner in which the wound in the bladder wall is sutured. 2. Careful attention to prevent slipping of the perineal tube. 3. Firm pressure upon the supra-pubic wound.

In closing the wound in the bladder wall, a continuous suture of catgut should be employed, and the sutures should be carried through the muscular coat. It will greatly facilitate this part of the operation if the rectal colpurateur is distended so as to bring the wound near the surface, as otherwise it is very difficult to place the suture accurately.

95 Park Avenue.

THE TREATMENT OF ACNE IN BOTH SEXES BY RELIEF OF GENITAL IRRITATION—A GENERALIZATION OF SHERWELL'S METHOD.

By J. M. WINFIELD, M.D.,
Attending Dermatologist to the Long Island Hospital Dispensary, Brooklyn, N. Y.

ALTHOUGH acne is the commonest of skin diseases, yet it is the one disease that is most frequently passed over with little or no treatment, the physician trusting the cure to developmental changes. The acne pustule will cease forming after an indefinite period, but the disfiguring marks may remain for a lifetime.

The object of this paper is to add the report of a number of successful cases to those already recorded in which treatment has been directed to the reflex origin of this disease.

All authorities writing on Acne vulgaris and Acne rosacea refer to uterine and other sexual pathological conditions as having a causa-

tive action in these affections, yet very little is said regarding treatment of these functional or organic irregularities. European authors, even the late works of Anderson and Crocker, ignore almost wholly any reference to general or local treatment of the sexual organs. The American writers have paid more attention to this etiological point. Prominently among them are Piffard and Robinson.

Early in the last decade Drs. Denslow[1] and Hyde recommended the use of ergot in the treatment of acne and its annex, rosacea. The theory was that ergot exerted a tonic action on the non-striated muscles surrounding the sebaceous glands, thereby enabling them to more readily expel their secretions.

It has been proven that ergot does have a good effect in certain cases in females where the menstrual functions were irregular, but in those cases the result appears to come from its oxytocic power rather than its tonic effect on the involuntary cutaneous muscles.

Dr. Piffard[2] places acne in the group of reflex affections, "in consequence of a firm belief that in the majority of instances it is not a primary condition, but one dependent on disease of other organs reflected on the skin. The organs specially involved are those connected with the sexual or digestive systems."

In describing treatment he recommends that strict search be made for sexual causes, and when found removed if possible. It is observed that acne is a disease of youth, and there are many conflicting opinions regarding sexual excess—be it from masturbation or excessive venery—acting as an aggravating cause. Neumann[3] says it occurs in persons of abstemious habits as well as those who are addicted to over-indulgences.

It would seem that masturbation has but very little to do with its causation, for we often see adolescents without acne who from their own confession have indulged in the common, if not universal, habit. Still, if this or any other mode of excess adds to the already existing passive congestion of the genital mucous membrane, undoubtedly there would be an outbreak of acne on the face and neck. There is at the period of puberty a hyperæsthetic condition of the genital apparatus, and ninety per cent of young males will be found to have hypersensitive urethral canals.

In girls at the beginning of menstrual life there are frequently a number of peculiar reflex nervous phenomena, which have more or

[1] Denslow: N. Y. Med. Journal, Feb., 1881.

[2] Piffard: "Materia Medica and Therapeutics of the Skin," Wm. Wood & Co., New York, 1881.

[3] Pullar's translation of Neumann's text-book, "Skin Diseases," London, 1871.

less effect on the cutaneous circulation of the face, which is often enough to cause acne. Nearly the same thing produces acne rosacea at the climacteric period. In addition to these physiological causes, we constantly hear the gynecologist lament the fact that so many young women have some form of menstrual irregularity such as dysmenorrhœa, amenorrhœa, or menorrhagia, all of which can produce enough reflex trouble to cause acne. Reflexes appear to play an active part in producing other skin diseases: for instance, urticaria seems to be a disease reflected from a deranged alimentary canal to the trunk, and chronic urticaria has been cured after operations for the relief of oöphoritis and salpingitis.[4]

The natural conclusion to be drawn is that acne is not a primary disease, but one derived from some other deranged organs, and those organs are most frequently the sexual.

In 1884 Dr. Sherwell,[5] of Brooklyn, published a report of a number of cases of acne in the male subject treated by the cold sound. His results were so uniformly good that his method was adopted by a number of dermatologists, among whom was Dr. Denslow,[6] of St. Paul, who read a paper at the ninth annual meeting of the American Dermatological Association, entitled "Urethral Irritation in the Male the Cause of Certain Neurosis, and also of Acne." In all of Sherwell's cases there were hypersensitive urethras; while Denslow reports cures following the relief of stricture as well as sensitiveness of the urethra.

The following personally observed male and female cases have been selected from private and dispensary practice. In nearly all of them the treatment of the acne by relief of genital irritation was not begun until after most other well-known remedies had been faithfully tried and found to be ineffectual. The male cases were systematically sounded at frequent intervals, as recommended by Sherwell.

Private Cases—Males.

Case I.—Male, aged 19. Good general health. Denied all venereal disease. Admitted having masturbated. Irregular in eating and drinking. Face and shoulder thickly studded with severe indurated acne, which has existed for about two years. Irregularities of eating and drinking corrected. External application of sulphur ointment and like measures. After continuing the general line of treatment for about three months without any effect on the disease, his

[4] Dr. E. Frank: Prag. med. Wochenschrift, No. 6, 1890.

[5] Sherwell: Journal Cutaneous and Venereal Diseases, Wm. Wood & Co., N. Y., Vol. II., No. 11, 1884.

[6] Denslow: N. Y. Med. Record, Wm. Wood & Co., Nov. 7th, 1885, vol. xxviii., No. 19.

urethra was searched, and a highly hypersensitive spot was found at the junction of the membranous and prostatic portions.

After discontinuing all other treatment the sounds were passed every other day for about one month, when the acne had about disappeared. Then the patient was lost sight of for six months. When he again reported the acne was all gone and has continued so for over two years.

CASE II.—Male, aged 20. General health—excepting a slight gleet—perfectly good. Habits at present correct. Has had simple acne for about two years, following an attack of obstinate gonorrhœa. Search was made for stricture, which was found at two and one-half inches. It was dilated until No. 24 French would pass without difficulty. By the end of three months the stricture was practically cured, and the acne was well and has remained so for over two years. No other treatment, external or internal, was used.

CASE III.—Male, aged 20. For four years has suffered from a severe indurated acne of face and neck. General health good. Denied venereal disease or masturbation. No other treatment was given except the cold sound, which was used twice a week for about a month without any effect on the disease. Then they were used every other day; at once the acne began to yield. Pustules ceased forming and the induration became less. At the expiration of four months from the beginning of treatment the young man was discharged, without any relapse as far as is known.

CASE IV.—Male, aged 17. Good health. Masturbated, but not excessively. Simple acne covering face and shoulders. The cold sound was used at once, supplemented by an ointment composed of resorcin and sulphur. The acne, as well as the desire to masturbate, rapidly grew less under treatment. Patient is still under observation, although he apparently would have been well long before this had he not grown careless. Negligence is the cause of a great many cases of failure in the cure of acne. Especially is it so when the sound is indicated. The patient gets the idea that such a unique method is unnecessary, and consequently grows indifferent, and either stops all treatment or continues in such an irregular manner that little or no good can be accomplished.

Dispensary Males.

CASES V., VI., VII., VIII., IX.—All males from the Long Island Hospital Dispensary. Ages ranged from 17 to 25 years.

As a rule their general health was poor. Acne of the variety found in poorly-nourished and strumous people. Local application of resorcin, ichthyol, and sulphur ointments. Internal treatment consisted of tonics, iron, quinine, and cod-liver oil. After a time their health began to improve, but the acne remained about the same. As a last resort the sounds were used, along with sulphuret. potassium lotion. In three of the cases the urethras were found to be exquisitely sensitive. The other two had slight stricture toward deeper portion

of urethra. The sounds were used every other day on all of the cases. The first three improved, but were lost sight of before cured. The strictures in the other two were dilated until a No. 24 French sound would readily pass. The improvement of the acne kept pace with the dilatation of the stricture, and in three months they were dismissed cured.

The following cases in females were treated on the same principle as the males. When there was found to be any uterine irritation or disorder, it was corrected if possible. In nearly every case of acne in the female there will be found some menstrual or genital trouble. Almost all women have a temporary outbreak of acne at the menstrual period, and if there is a chronic rosacea it is apt to be aggravated at that time. If it were not for the difficulty of searching for uterine disease in young unmarried women we would have fewer cases of acne in the sex. Notwithstanding this, it is as much the duty of the dermatologist to search every organ as a possible cause for disease of the skin as it is for the gynecologist to search for disease in his special sphere. If we are unable to institute an examination to determine the exact nature of the urethral disorder, we can somewhat relieve the vaginal hyperæmia by hot douches, as recommended by Robinson,[7] which were used in the following cases.

Hospital and Private Cases—Females.

Case I.—Female, single, aged 20. Acne and rosacea for two years. She was of a highly nervous organization. Menstruated when she was about 15 years old, and it was always painful and irregular. General health poor. Was given a pill composed of iron, arsenic, and ergotin. Local application of sulphur ointment and resorcin lotion. This treatment was continued for about six months without any permanent effect. Then the hot vaginal douches were begun, and at once the acne as well as the painful menstruation subsided, and by the end of three months (*i.e.*, nine months from beginning of treatment) she was dismissed cured, which lasted about eight months, when there was a slight relapse. The patient resorted to the douche without seeking advice. This time the cure has been permanent. In this case the douche was given daily for four days before the expected period, discontinuing them when the flow was established.

Case II.—Girl, aged 14 years. Health good. Menstruated at the age of 10½, which had always been without pain. Hesitating to use the vaginal douche on such a young girl, all other available means were tried, with no beneficial result. Her mother was finally persuaded to use the douche every morning during the inter-menstrual period.

[7] Robinson: "Manual of Dermatology," N. Y., 1885, p. 262.

In less than a fortnight improvement could be observed, which continued until complete recovery in about six weeks, with no relapse for over two years.

CASE III.—Female, aged 24. Has had acne simplex and dysmenorrhœa since her sixteenth year. The acne is aggravated at each menstrual period. She received no local treatment except hot facial baths. Internally, fifteen drops of ergot, t. i. d. Hot douches every other day, discontinuing at the menstrual period. Immediate improvement began, and continued until the fifth month, when the acne was cured and the dysmenorrhœa greatly relieved. There has been no relapse for over two and a half years.

CASE IV.—Seen at the Long Island Hospital Dispensary. German-American girl, aged 17, of the type often called neurolymphatic. Has had simple acne since the establishment of the menses in her fourteenth year. Never had any pain or irregularity at the menstrual period, but the acne was always aggravated.

She was directed to take plenty of out-door exercise and to attend to her diet. Was given tonic treatment and a five-per-cent (℥) naphthol ointment locally. This met with partial success. After two months the hot douche was begun. The good result began immediately and continued so for four months, when a relapse occurred, the patient having grown tired of treatment. She is still under observation.

CASE V.—Married woman. Never been pregnant. Menstruation irregular and very painful. On vaginal examination the genital organs were found to be small and undeveloped, and there was stricture of the cervix uteri, causing an obstructive dysmenorrhœa. Treatment consisted of dilatation of the cervical stricture and hot vaginal douches. The acne pustules ceased forming as the abnormal genital condition improved. By the end of six months the face presented a greatly improved appearance. The enlarged capillaries which remained were scarified and a fifty-per-cent alcoholic resorcin wash applied. Internal treatment consisted of iron and ergot. A letter just received states that her face is well and that she is in good general condition. Now over two years.

CASE VI.—Female, married 12 years. Has had two children. Complained of leucorrhœa and general pelvic distress. Examination revealed an extensive bilateral laceration of cervix. There was a mild rosacea of the chin and nose. Her health was poor. General tonics were given and a local preparatory treatment for operation on cervix. Nothing was done for the acne, which disappeared after the operation and has remained a thing of the past for nearly two years.

CASES VII., VIII., IX.—Were all married women, seen at the Long Island Hospital Dispensary. Ages ranged from 20 to 40 years. In all there was some form of genital irritation. Two had retroflexions and were in a low anæmic state. Case IX. had a severe bilateral laceration. The acne was the simple form. They were referred to the Gynecological Department, where they received the proper treatment, and by the time they were dismissed their skin was well.

In conclusion, it will be observed that the relief of genital irritation will not cure all cases of acne. The hot douche or cold sound is of no avail in strumous or anæmic subjects until after they have had tonic treatment and improved hygienic surroundings. Then these local measures may and do prove a valuable adjunct. On examining the above list of cases, it is noticed that the best results were obtained in private practice rather than in those from the dispensary. The explanation is that it is exceedingly difficult to persuade the average dispensary patients to use these methods in the proper manner or to continue them for a sufficient length of time. It is hard to convince them that treatment applied to the sexual organs can have any curative effect on a disease of the skin located on the face. Another cause of failure is that they come from strumous ancestry, live in unhealthy houses, and eat unwholesome food. Still another is that these people pay little or no attention to the healthy action of the skin. In unmarried females the objections to a vaginal examination are so great that we are often deterred from insisting on the proper use of the hot douche. Therefore in these cases we have to work blindly, while in private practice we can prevail upon our patient to do as we wish. Still, if in all cases of acne that come under our notice we were to insist oftener on measures of relief directed to the genital apparatus, the results would be better in this common but annoying disease.

11 NEW YORK AVENUE.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

204TH REGULAR MEETING.

DR. E. B. BRONSON, *President, in the Chair.*

Bassorin Paste: A New Base for Dermatological Preparations, was the title of a paper by DR. G. T. ELLIOT, who also demonstrated various combinations of drugs with the new base.

DR. FOX said that several years ago he presented a somewhat similar preparation, consisting of tincture of benzoin or tolu thickened with oxide of zinc. This preparation spread upon the skin dried quickly and formed a coating somewhat similar to this one. He used it for some time and with a certain degree of success, but he found that its therapeutic efficacy was limited.

He believed that in the majority of chronic skin affections the drug should be well rubbed into the skin, and thought that the efficacy of tar and chrysarobin depended largely upon the vigor with which they were applied. In psoriasis he obtained better results with chrysarobin in ointment form than combined with liquor gutta-perchæ. In superficial inflammatory conditions

these varnishes have a good effect, but in deep-seated infiltrations they are not to be relied upon.

DR. MORROW was disposed to think very favorably of this new preparation which Dr. Elliot had brought forward. He had obtained very satisfactory results with samples which had been furnished him. In many cases of skin trouble it was desirable to protect the surface absolutely, and he thought that could be more effectually done by such preparations as the ones shown or by the gelatin preparations of Pick than by ointments. All of us recognized the advantages of fixed adhesive preparations over ointments in the treatment of many circumscribed forms of skin diseases, as these preparations were less liable to deteriorate, were cleaner, and could be accurately limited to the diseased patch. In the treatment of psoriasis he found no difficulty in producing all the inflammation necessary with chrysarobin in liquor guttaperchæ, and thought it would be a step in the backward direction to use the preparation in the form of an ointment.

He had used the preparation of Dr. Elliot in pruritus hiemalis, where it was desirable to protect the surface from contact with the air, and he found it had a most happy effect. He had used it also in psoriasis, but was unable to express an opinion on its usefulness in this affection, on account of the limited time in which it had been used.

DR. PIFFARD stated that ointments should be used where absorption of the drug was indicated, and cerates where only a surface effect of the remedy was desired.

In the last revision of the Pharmacopœia, it was unfortunate that the majority of the cerates were excluded. It was almost impossible to obtain a good cerate, unless one wrote a prescription containing all the ingredients to be used.

He did not like the present zinc or mercurial ointments, and was in favor of a return to the cerates or to some good substitute for them. He thought the preparations presented by Dr. Elliot combined the desirable properties of the cerates with excellent qualities of their own, and if they proved to be as useful practically as they appeared at first sight, he thought there was a field of usefulness for them.

DR. BULKLEY had been watching the effects of these preparations for some weeks, and was well pleased with the results in some of the more acute congestive conditions of the skin. In the chronic affections, on the other hand, the results had been disappointing; in psoriasis he had not obtained the results that he anticipated.

He desired to indorse the statement of Dr. Fox, that where there was thickening of the skin remedies should be applied that would penetrate deeply into the tissues. At first he had been well pleased with the gelatin pastes, but was using them less and less frequently.

DR. ELLIOT, in closing the discussion, said that he had found the preparation not only of benefit in superficial, but also in deep-seated and chronic skin affections.

In a paper published elsewhere (JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, February, 1891), a number of cases of chronic skin troubles were reported by him which had quickly yielded to remedies combined with the base. That the bassorin paste did not interfere with the action of remedies mixed with it was shown, he thought, by the fact that he frequently had had to make their strength weaker than in ointments. For instance, on the same

person resorcin in the strength of 5 per cent when mixed with bassorin had produced so decided an effect that it had to be diminished to 3 or 2 per cent, whereas in an ointment the drug had not caused any perceptible reaction. Certainly a part of this was due to the fact that the paste kept the resorcin in constant contact with the skin, but still it demonstrated also that it did not interfere with the action of a drug incorporated with it.

In psoriasis it had the advantage over ointments containing chrysarobin, etc., of not producing pigmentation of the skin and dermatitis, though its curative effects were somewhat slower.

In all parasitic eczemas and in other diseases, his experience had been such that he could confidently recommend the new base.

Tertiary Ulceration of the Nose.—Presented by DR. PIFFARD. The patient,

a man of about 40 years of age, had been under the treatment of two quacks in this city for several months for cancer, without benefit.

The condition is shown in the accompanying illustration, which is a reproduction of a photograph taken by Dr. Piffard. The affection has been improving very rapidly during the past week under mixed treatment.

Absolutely no history of primary lesion could be obtained, and a very doubtful history of secondary eruption.

Sub-ungual Keratosis.—An unusual example of this affection was presented by DR. CUTLER, showing a development of horny tissue beneath the nails of the fingers several millimetres in thickness. A keratosis of the palms was also present.

The Treatment of Skin Diseases by the Use of Dr. John Chapman's Method of Cold to the Spine was the title of a paper read by DR. B. O. KINNEAR (by invitation), in which a number of obstinate cases of eczema, acne, etc., were reported which had been cured by this method.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY DISEASES.

R. W. TAYLOR, M.D., *Chairman.*

At a stated meeting, February 12th, 1891, Dr. Robert W. Taylor was elected chairman and Dr. S. T. Alexander secretary for the ensuing year.

DR. ALEXANDER read a paper, **Report of a Rare Case of Papillary Adenomatous Sarcoma of the Bladder Removed by Supra-pubic Cystotomy.**[1]

DR. L. BOLTON BANGS agreed with the author that it was very difficult at the present time to satisfactorily classify tumors of the bladder. The diagnostic criteria at our command are not sufficient to enable us before the operation to determine positively the nature of the tumor, nor even to base a reliable prognosis after an operative measure has been resorted to. One of his cases of tumor of the bladder, operated upon over two years ago, was, according to the report of the pathologist, a case of simple papilloma. He, however, felt some doubt whether it was free from malignant elements, and consequently he was not surprised a few months ago to hear from the patient's physician that there had been a recurrence, and later the patient died. Unfortunately an autopsy could not be obtained, but it seemed evident that the process must have been malignant.

He had operated upon a case recently which was of interest as showing difficulty in diagnosis. There was a characteristic history of intermittent hæmaturia, irritable bladder, pain at the end of micturition, progressive emaciation. He made more than one examination before operating, and felt apparently a mass on one side of the bladder. The patient complained of sensibility and pain when that part of the bladder was touched, and increased hemorrhage was produced. Not being entirely satisfied, he tried the cystoscope, but the injected fluid immediately became tinged red, so that nothing could be satisfactorily seen. He felt justified in opening the bladder and removing the tumor if possible, but was surprised, on making a supra-pubic section, to find near the sphincter only an area the size of a quarter of a dollar studded with small papillæ projecting very little above the level of the mucous membrane. These were curetted with the sharp curette, but were lost, and he was therefore unable to give the microscopical appearances or say what was the nature of the change. They appeared macroscopically as a granular or tubercular growth. There was no infiltration of the mucous membrane or submucous tissue as far as could be determined.

DR. W. K. OTIS did not approve of making perineal section for diagnostic purposes in these cases. After it was performed the diagnosis might still remain uncertain. The evidence was usually sufficient to justify one in proceeding at once with supra-pubic cystotomy, which was not much more dangerous and which would permit of curative treatment if this were possible.

DR. R. W. TAYLOR read a paper on **Some Interesting Cases of Genito-urinary Diseases.**[2]

The next paper was by DR. GEORGE H. FOX—**Certain Diagnostic Features of Cutaneous Syphilis**, with photographs.

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[1] See p. 86.

[2] Will be published in this JOURNAL.

Dr. Fox first presented a young man illustrating the occurrence of the small miliary syphilide in a strumous constitution. The color was of a purplish-red, different from the ordinary copper-colored cutaneous syphilide described in the books. Moreover, the patient complained of itching of the face and some portions of the body. There had been no throat symptoms, no arthritic symptoms, the hair had not fallen out, he had complained of no headache, and in spite of the lesion on the penis he claimed never to have had intercourse. The primary eruption had appeared three months ago and the lesion upon the penis five months ago.

The diagnosis of cutaneous syphilis, he said, was usually based upon the color of the eruption, the peculiar configuration which it almost invariably assumed, the absence of itching and other subjective sensations, and in many cases upon the history, and in cases of doubt upon the results of specific treatment.

As to the color, as a rule it was dark brown, "copper color," or the color of "lean ham." But there were cases in which the color did not assume this characteristic appearance in strumous patients like the one presented, where the color was purplish, like that of lupus; in some others it was yellowish, as in psoriasis.

The configuration of the eruption often enabled one to make the diagnosis of syphilis at a distance. In the pustular syphilide the touch was of value in diagnosis. He would never forget the phrase used by his honored teacher, Prof. Tilbury Fox, of London, in describing syphilitic lesions as "fleshy lumps in the skin."

Photographs were presented representing syphilitic eruptions of various forms and showing differential points from other cutaneous lesions. Large papillary syphilides often assumed a circular form. Sometimes there was a raw surface on the skin at the seat of the papule, resembling the mucous patch upon the lips. In the tubercular or pustular syphilide the annular appearance was very characteristic. In many instances some of the lesions were serpiginous, showing a tendency to advance at the border while healing in the centre.

A photograph of a case of chronic serpiginous erythema was shown, in which, although the grouping was similar to some cases of syphilis, the diagnosis was plain, as the lesion was simply a hyperæmia, while in syphilis there was infiltration and the feeling of a fleshy lump.

The late gummatous infiltration of syphilis also showed the same tendency to advance at the margin and to heal at the centre, producing a characteristic horseshoe or kidney-shaped ulceration.

The greatest difficulty in diagnosis related to late lesions of the palms and soles. Some English writers had claimed that a single scaly patch in the centre of the palm was indicative of syphilis, but the speaker had seen a single scaly patch of eczema occupy the palm. In eczema there was never that healing in the centre of the lesion or patch like what was seen in syphilis. Another diagnostic point: where both palms were affected, nine times out of ten it meant eczema; where but one was affected, nine times out of ten it meant syphilis.

As to confounding syphilis with psoriasis, it was true that even as great authority as the late Prof. Hebra had stated that psoriasis never affected the palms, but the speaker had seen exceptions to this rule. Usually, however, the palms and soles in psoriasis were free. In psoriasis there was very little

infiltration of the skin, while commonly there was considerable scaling of the epidermis. The knees and elbows were often affected in psoriasis, but the lesions in syphilis might also be grouped at these points.

Syphilitic alopecia rarely occurred except in the first stage of the disease. Pustules might form in the hair and sometimes considerable hair become loosened, but usually it was in spots. Years ago, however, alopecia areata was often mistaken for syphilitic loss of hair.

To diagnosticate syphilis from lupus was sometimes difficult. The duration of the disease would be an important aid. Syphilitic gummatous infiltration was sometimes mistaken for sarcoma or other malignant disease. A case was exhibited by photograph in which a syphilitic gummatous tumor of the lip had been mistaken for epithelioma, but specific treatment caused it to promptly disappear. Two other like cases had come under his notice soon afterward. Cutaneous syphilis might also be mistaken for mycosis fongoides. A photograph of a case was shown in which large tumors had formed on the body, the case ending, as usual, fatally.

Leprosy was another affection which might sometimes readily be mistaken for cutaneous syphilis. He had himself mistaken one case of syphilis for leprosy in a woman who had come from Norway and who had the hand of a leper. But according to Dr. Taylor, who had had the case long under observation, it was a case of syphilitic neuritis with deformity of the hand. The photograph of a case of double zoster resembling syphilis was also shown. The history of the case, the grouping of the eruptions, and failure to respond to mercury showed it was a case of double zoster. A photograph was also shown of a patient who had the characteristic teeth of congenital syphilis, and afterward the lesions of a recently-acquired syphilis.

DR. P. A. MORROW agreed with Dr. Fox, that the color of the eruptions in syphilis was not always of the classic hue described in text-books. The complexion of the individual materially modified the color of the eruptions, it being brighter and more pinkish in blondes, more sombre and brownish in brunettes.

He also agreed with the statement that it was sometimes impossible to differentiate between syphilitic and eczematous eruptions upon the palms. Often such eruptions, even when of syphilitic origin, failed to respond to specific treatment. Besides the differential points mentioned by Dr. Fox, he would say that the eruption, when syphilitic, seldom crept over the dorsal surface, while it not infrequently did when eczematous. He did not think it possible to arrive at a positive conclusion from the character of the infiltration or the scalloped outline of the margin. As to psoriasis of the palms being mistaken for syphilis, it seldom happened, simply because psoriasis affected the palms infrequently. He had seen perhaps a dozen cases where psoriasis had invaded the palms, but never one in which it was limited to this region.

He believed it often impossible to differentiate between lupus or epithelioma of the nose and syphilis from the objective appearances alone. The history and pathological coincidences might clear up the diagnosis. Leprosy might readily be mistaken for syphilis. About two years ago he exhibited a series of photographs before the American Dermatological Association illustrating leprosy, and many of the members could hardly be convinced that the lesions were not syphilitic, yet careful inquiry had enabled him to eliminate syphilis. In tubercular leprosy, especially, the lesions often resembled those

of syphilis very closely in their localization, in the character of the infiltrations, and in their clinical course.

DR. BREWER read a paper—**The Contagiousness of Chronic Urethral Discharges.**[1]

DR. F. R. STURGIS said that he must confess to skepticism as to whether the gonococcus had been proven to be the cause of gonorrhœa. Undoubtedly it was present in many cases of urethritis, but in others it was absent, yet in both instances the disease seemed to run precisely the same course. He was inclined to think that the majority of cases of chronic urethral discharge were comparatively innocuous. There was always risk in giving an opinion of this kind, since conditions of excitement might arise which would render the discharge capable of producing disease—sexual excess, alcoholic indulgence, etc., might set up an acute inflammation. In doubtful cases the rules laid down by Dr. Finger should be followed for the sake of safety. Doubtless all had seen cases of chronic urethral discharge in a man with the *tripper-faden* present, yet no infection take place in the wife. In fact, it seemed a great deal harder to convey the disease to women than to men.

DR. BACHE MCE. EMMET spoke upon the gynecological aspect of the subject. Gynecologists as a rule, he said, were called in only to witness results, seldom or never in time to prevent them. He did not doubt but what the illustrative case so graphically pictured by Dr. Brewer was but one of many which had not come to light. Gynecologists often had to treat women who before marriage had been in perfect health, but subsequently, owing, doubtless, to gonorrhœal infection, had acquired pyo-salpinx, or other disease necessitating a serious operation and one which must leave them sterile for life. Sänger had considered one-ninth of all gynecological cases due to gonorrhœal infection, and it was evident that if the serious nature of the inflammation in the uterus or elsewhere were early recognized and treated with a view to destroying the infectious element, there would be fewer cases of tubal and ovarian disease. Dr. Brewer's case was like one first described by Dr. Noeggerath, in which the woman's health, previously good, had been destroyed by gonorrhœal infection. This author's views were, he believed, becoming more and more accepted, that tubal disease, repeated attacks of pelvic peritonitis, etc., were dependent upon such infection.

DR. W. K. OTIS thought that while many might not be ready to accept the views of Noeggerath, yet a physician would do wrong to give his consent to a marriage without first curing his patient of a chronic urethral discharge. The influence of the *tripper-faden* was exceedingly difficult to solve. It was very common to find men who, having had one attack of gonorrhœa, were troubled with recurrences, and it seemed hardly reasonable to suppose that each new attack had come from reinfection. He believed the explanation lay in the fact that the gonococcus or other germ lay latent in the urethra, and owing to some excitement or irritation woke up and produced an active discharge, one which it was very difficult to differentiate from the original disease. It was, therefore, very difficult to say whether a man who had had such repeated attacks might not be able to communicate gonorrhœa or some serious inflammation to his wife. He was disposed to think that many cases of uterine and tubal trouble were due to a septic inflammation which the wife acquired through the husband, who had previously suffered from gonorrhœa,

[1] See p. 81.

but in whom the gonococcus had disappeared, while a discharge capable of setting up septic inflammation yet remained or developed under exciting influences.

DR. F. TILDEN BROWN was fully impressed with the necessity of great caution in giving a man permission to marry who had a chronic urethral discharge. The reader did not mean, he thought, that in all cases in which the *tripper-faden* was present there was ability to set up a gonorrhœal inflammation. He had in a number of cases been unable to develop the gonococci by instrumental irritation or otherwise where the *tripper-faden* were present. It was in the bulbous portion of the urethra that the gonococcus was most likely to remain and some time afterward wake up from its latent state and give rise to a fresh attack.

DR. P. A. MORROW was fully in accord with the reader of the paper as to the importance of the question under discussion both from a medical and a social standpoint. It would be impossible to lay down a safer rule of conduct than that formulated by Finger, but at the same time he thought it might be unnecessarily stringent in certain cases—that is, to make the entire disappearance of the *tripper-faden* an essential condition of giving consent to marriage. His procedure, involving the use of nitrate of silver or bichloride injections with the view of re-establishing a purulent discharge, seemed hardly necessary. He did not agree with the reader that the relations of this subject to marriage were as important as those of syphilis. At the same time he thought any physician would be culpable who gave consent to marriage when there was any reasonable fear of gonorrhœal contagion. The old rule was comparatively simple, namely, as long as there was any purulent element in the discharge it was unsafe for the man to marry, but the discovery of the gonococcus and its tendency to lurk without any evident symptoms for a time and then become under stimulation an active agent of contagion, had introduced an element of confusion. He had never seen contagion follow marriage with a man who had had no discharge for years, as in the case described by Dr. Brewer. Perhaps, as suggested by Dr. Sturgis, the rarity of such an occurrence might be due to the comparative insusceptibility of women to infection. Too much laxity was exercised by physicians in deciding upon a man's fitness for marriage, and he regarded the warning conveyed in the author's paper as extremely timely and pertinent.

DR. L. B. BANGS thought that while it was not definitely proven that the gonococcus or some germ was the cause of gonorrhœa, yet it was probable, and the supposition gave us fair reason to look upon the presence of the *tripper-faden* with suspicion. Yet the *tripper-faden* doubtless were sometimes simply an exaggeration, so to speak, of the normal condition found in the urine—made up of rolls of mucus, etc. While the *tripper-faden* alone should not preclude marriage, yet the presence of the gonococcus, he thought, should. And it should not be forgotten, in considering the results of infection, that pus-producing germs might accompany the gonococci.

DR. ALEXANDER said the fact should be borne in mind that many patients with gonorrhœa left their physician before they were completely cured. They left as soon as the urethral discharge stopped, yet the *tripper-faden* would be found still to contain the gonococcus, ready to multiply under slight provocation. He cited two illustrative cases, one where the unsuspecting husband got gonorrhœa from his wife, who had had connection with his friend; the other where a man became infected from a mistress in whom the

gonococcus was found only after most careful search in the cervical secretions.

THE CHAIRMAN said Dr. Brewer's case was an unusual one, yet he was undoubtedly right in saying that where the *tripper-faden* contained the gonococcus consent should not be given to marriage. He agreed with Dr. Otis that there might be other germs present in the urethral discharges capable of giving rise to trouble, though less in degree, perhaps, than the gonococcus when this was present. Much study would yet be necessary to determine whether the gonococcus really lay latent for so long a time and then woke up and produced inflammation anew, or whether some other micro-organisms were the cause of the after-troubles in persons who had once had gonorrhœa.

DR. BREWER closed the discussion.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Treatment of Tuberculosis by the Method of Koch.—In France, as in all other countries, the attention of the medical public has been for two months past almost exclusively concentrated upon the discovery of the celebrated savant of Prussia. I may say in all truth that it has been received by us with the greatest cordiality, that from the first all of our physicians have joined in the ardent wish that it might fulfil all that it promised, and that those who were fortunate enough to receive a supply of the lymph began to experiment with the best possible faith, although with the greatest prudence.

The state of feeling in Paris during the first twenty days which followed Koch's communication presented a curious condition. All patients affected with lupus or visceral tuberculosis spoke of going to Berlin to be treated : they refused to continue all other medication, and importunately demanded the marvellous injections. The physicians themselves seemed to be scarcely less eager, and they advised all those whose condition was not urgent to only wait until they could procure the lymph. During three weeks Koch was for us a sort of beneficent deity. Nevertheless a certain number of our physicians, particularly the French dermatologists who have most carefully studied cutaneous tuberculosis, preserved a marked incredulity in seeing announced radical cures of lupus obtained within a few days. The results, unfortunately, have shown that they were right, at least in a certain measure.

In the first moment of enthusiasm three of the most distinguished physicians of the hospitals of Paris went to Berlin in order to study closely the results obtained. Upon their return to France they made before the *Société Médicale des Hôpitaux*, December 9th, 1890, a collective communication which has singularly tended to make all unprejudiced minds more reflective. They report as a result of their observation a distinct impression of disillusion, I should say even of discouragement.

M. le Dr. Terray, who had proposed to study the general action of the lymph, declares, in fact, that it is a pyrotogenic agent in its general effects, and as to its local effects it is an agent which inflames the capillary system with a special determination of action upon tissues occupied by the tuber-

cle bacillus. While the pyrotogenic action of this substance appears especially marked in tuberculous subjects, *it may, on the one hand, fail in them, and, on the other hand, be manifest in subjects who are not affected with tuberculosis;* consequently its diagnostic value is, according to him, most questionable. The phenomena which are produced after the injections seem to depend upon a sort of paralysis of the vaso-motor muscular fibre, determining in certain capillary systems a paretic congestion, involving more or less gravely the heart itself and touching also somewhat the peripheric muscular apparatus. He thinks with Prof. Ewald that these conditions should cause us to absolutely reject the employment of this method: 1. An extensive generalization of the tubercular lesions: 2. An adynamia or marked feebleness of the phthisical patient. 3. The hæmoptoic form of the disease.

M. le Dr. Cuffen studied more especially the action of the lymph upon the phthisical patient. He also has seen tuberculous individuals unquestionably refractory to the action of Koch's lymph. He has observed grave accidents as a result of the injections, and in his opinion these accidents are of two orders, the first due to a too intense congestion, the second to an *acceleration of the tuberculization.* On the other hand, he has sometimes seen produced an improvement of the general condition, but he has not seen a single case of cure of tubercular lesion of the respiratory apparatus.

M. le Dr. Thibierge, the pupil of Dr. E. Besnier, occupied himself with the study of the results obtained at Berlin in lupus. Now, *among all the patients, without exception,* whom he observed in that city, even those that had been inoculated from the beginning of the experiments—a period of almost two months—he found, by a minute objective examination, lesions presenting all the clinical characters of the nodules of lupus vulgaris. It is well to add that certain of them were represented as cured. Neither does he hesitate to declare that by the method of injections of Koch's liquid alone, *there does not yet exist a single case of even an apparent cure of lupus.* He believes, moreover, that analogous with the action of an intercurrent erysipelas, which modifies lupus and scrofulo-tuberculous lesions, Koch's lymph is without doubt superior to all other known treatments for tuberculous lupus. Later researches have not fully confirmed this favorable appreciation of Dr. Thibierge.

I shall now call the attention of your readers who wish to have an idea of the principal French experiments upon this question to a series of lectures given by Prof. Cornil at the Laennec Hospital. This savant bacteriologist has himself seen produced quite often after the injections a diminution of oxy-hæmoglobin. This diminution occurs ordinarily 24, 48, or even 72 hours after the introduction of the lymph into the economy. It becomes accentuated after several injections; but these phenomena, like those of febrile reaction, are subject to all possible variations according to the individuals. The conclusions of Prof. Cornil are that up to the present we are justified in continuing the injections of the lymph in lupus or even in cases of apyretic pulmonary tuberculosis when the general condition is sufficiently good; it should not be employed in other cases. According to him, this medication should only be employed in lupus subjects where there are no serious complications of the lungs or of other organs, especially the kidneys, since it produces hæmaturia and albuminuria in certain cases. From the point of view of the histological modifications which take place in the lupus tissues under the influence of the lymph injections, Prof. Cornil has found that

the congestion is followed by a considerable migration of white globules, which are discharged on the surface of the skin in an abundant liquid secretion, which concretes in the form of crusts. This liquid secretion and these crusts contained, in one case especially studied in this particular, numerous bacilli of tuberculosis. This evacuation of the bacilli cannot but be, he adds, of advantage to the patient.

The physicians of the *Hôpital Saint-Louis* organized as a commission under the presidency of their dean, Dr. Vidal, for the purpose of studying the effects of the Koch lymph upon lupus. Here are the first results of their labors (January 8th, 1891). Thirty-two patients have been inoculated; the first inoculations were made November 30th, 1890. The patients have been inoculated from four to six times: an average interval of from four to eight days has intervened between the injections. In some of the patients severely affected by the first inoculation the interval has been ten days. The doses injected have always been small. After certain accidents the physicians of the Saint-Louis have fixed upon one-half milligramme as the commencing dose; they increase this by one-half milligramme each injection until they obtain a reaction elevating the temperature to 39° (102.2° F.). For succeeding injections they do not surpass the dose which has been followed by this reaction as long as the temperature of 39° is attained by this dose. They have observed that in making the injections too near together the patients remain more enfeebled, become more rapidly anæmic, and their disposition to local reaction is more quickly exhausted. They have been especially impressed with the extreme irregularity of the general reaction, and with the fact that the local reaction bears no direct relation to the general reaction. *Very often lupus non exedens shows no local reaction when the general reaction is intense.* They have often observed *an intense reaction follow the injection of a demi-milligramme of lymph even after several inoculations.*

On the other hand, the effects of the lymph, consisting in congestions and inflammations, may be determined upon different organs of the economy in a most unequal manner, and this inequality existed not only in different patients, but also in the same patient in different inoculations. The organs originally diseased were ordinarily those which were the seat of the greatest congestion, *but it may happen that organs the most healthy in appearance may be equally affected.* They have noted especially the congestion of the base of the lungs, the tumefaction of the spleen, albuminuria and hæmaturia, symptoms of myocarditis and of endocarditis: they have twice seen appear upon the face tumefactions resembling erysipelas, but which were not, since the cultures did not give the streptococci, etc.

As to the therapeutic effects obtained in lupus, the physicians of the *Hôpital Saint-Louis* still reserve information upon this point which will be the subject of a further communication. We cannot too strongly approve this wise prudence. Nevertheless, we think ourselves authorized in saying that up to the present time the results observed have not rendered null the enthusiasm for this method. Certainly they have demonstrated some excellent results in ulcerous lupus. I have seen a case of enormous lupus of the entire face, ineffectually treated, it would appear, for a long time, very much ameliorated by a few injections of the lymph after local reactions of the greatest intensity. I have seen others, again, which, after two or three injections followed by local reaction, took on a better aspect: they were flattened and seemed to be in process of cure. On the other hand, in other cases there was

not the least curative effect, and *to conclude, in none of the patients of the Hôpital Saint-Louis has there been even an apparent cure.*

In my next letter I shall give you in detail the definite results such as will be made public by the commission of the *Hôpital Saint-Louis.* I shall at the same time speak of other works upon the treatment of lupus which are at present in process of publication in France, the two most important of which are those of Messrs. Besnier and Leloir.

I will add only one word upon the method of Koch. It is that, accepted with much reserve by the physicians of the Saint-Louis, it has already been abandoned by the physicians of the general hospitals of Paris who are occupied in the treatment of diseases of the lungs, and by the greater number of surgeons of the same hospitals who treat local tuberculosis other than lupus.

Prof. Verneuil, professor of clinical surgery in the *Hôtel Dieu de Paris*, has tabulated the results of this method in one of his recent lectures (*Bulletin Médicale*, January 21st, 1891):

Cures authentic and durable, ...	Still to be demonstrated.
Temporary improvement, ...	A small number.
Permanent improvement, ...	Much more rare.
Stationary condition, bad effect after several weeks' treatment, ...	Cases quite common.
Local aggravation more or less serious, but transient, ...	Ordinary result.
Persistent local aggravation, ...	Very often observed.
Accidents, grave, developing in organs healthy, or at least non-tuberculous, ...	Frequent.
Accidents immediately fatal resulting from local aggravations or lesions of sound organs, or from infection created by the lymph, ...	Already numerous.
Delayed fatal accidents, ...	Many already noted.

Certainly this picture traced by Prof. Verneuil appears to us a little too darkly shaded, but we must remember that it is based upon positive facts, many of which come to us from Germany. This violent reaction has been called forth by the very general enthusiasm with which the discovery of the Berlin savant was received. The disappointment has been so much the more terrible, as the hopes excited were the most grand. While I do not feel qualified to take part in this important debate, having myself made no experiments, yet from all that has been written and said, it seems to me that it will require a long time to soundly appreciate this therapeutic method, but for the present we must renounce the magnificent hopes of the cure of tuberculosis which it has led us to conceive.

Treatment of Scleroderma in Bands and in Plaques by Electrolysis.—I presented before the French Society of Dermatology and Syphilography, December 11th, 1890, a patient affected with a band of scleroderma extending from the superior third of the right arm to the thumb. It formed a plaque of from 3 to 6 centimetres in width, in the transverse direction, of considerable thickness which was readily appreciated when the attempt was made to seize the integuments between the fingers. At the inferior portion of the thumb it was impossible to mobilize the skin, which seemed to be solidly united to the subjacent tissues. The patient, who was a cutter by occupation, could use

his scissors only with great pain ; he immediately experienced a sensation of marked heaviness and fatigue in his arm. He had been seen and observed during several months by Dr. E. Besnier, who had tried different forms of treatment without the least result, and who referred the patient to me in June, 1890. Up to the commencement of December I had given him fourteen *séances* of electrolysis ; each treatment comprised from 12 to 16 punctures with the electrolytic needle ; I passed at each puncture a current of 5 to 10 milliampères during 15 to 20 seconds. My operative method was practically the same as that employed in the treatment of keloid, and which I have made known to the readers of this JOURNAL in former letters. I made the punctures principally in the lower portion of the plaque, since here it was much more prominent and indurated. From time to time I made two or three punctures in the median portion.

From the first two *séances* both the patient and myself were satisfied in the most positive manner that the affection was arrested in its course. Since then it has not increased ; on the contrary, it has shown a marked tendency to retrogression. According to the patient, the movements of his arm have become much more free and the exercise of his work is much easier to him. From an objective point of view the plaque is less colored, less prominent, not so tense and less thickened ; it has diminished almost one-half. While the electrolytic needle has never been directly applied to the superior portion of the plaque, this part has undergone, like the others, perhaps even more so, the process of retrogression. This fact seems to prove that the action of the electrolytic current may be exercised in such cases at a distance. During a long interruption of the treatment, through the months of August and September, the affection, far from increasing, appeared to have further retroceded a little. This important fact proves that the effect of the treatment is only slowly exhausted after the cessation of its employment. We may conclude that it is not necessary to make the *séances* close together. Another fact, which, like the one I have just cited, has been developed as the result of my personal observation during the past year, is that electrolysis exercises in certain cases a positive action upon sclerodermic plaques and rapidly arrests their extension and course.

The Rule of Conduct to be Observed when One is Consulted by a Nurse Relative to a Syphilitic Nursling.—Prof. Fournier has recently studied in his clinics of the *Hôpital Saint-Louis* this very important practical question. It is most complex. If it concerns a nurse in the country nursing an infant whose family is absent, the physician should examine the child and warn the nurse of the danger she runs in nursing it ; he should do this fully, and explain with the utmost minuteness the grave dangers of contagion which the nursling carries to its *entourage*. But the savant professor does not think that even in such a case the physician should pronounce or write the word syphilis, for this declaration adds nothing to the preservation of the nurse, who is already fully forewarned, and, moreover, to declare that the infant is syphilitic is to announce that the parents are also syphilitic and to proclaim it publicly, since the nurse will not fail to repeat it to all of her acquaintances.

If it concerns a nurse living in the family of the nursling, and who is always readily recognized in France by her peculiar dress, the physician should not be silent, for to refuse to give a consultation to this woman is to expose her to contract syphilis and to unconsciously propagate it among those

with whom she is brought in contact. If the child is recognized as being syphilitic, it is better to say to her that she runs a great danger in continuing the nursing, and nothing more. The physician should in such a case positively refuse—(1) to make known to the nurse the true nature of the disease of the nursling; (2) to give a certificate, which might become in the hands of the nurse a means of intimidation or extortion against the parents; (3) to even give a prescription, for he has not to treat the child, and this prescription would reveal the nature of the disease and constitute an evidence of the syphilis of the parents.

PARIS, January 21st, 1891. L. BROCQ.

Selections.

Koch's Method in Lupus. Effects of the Lymph in other Affections.

Two and a half months have now passed since Prof. Koch aroused the enthusiasm of the whole medical world by the announcement of his discovery. This early enthusiasm has been succeeded by a period of hesitancy, doubt, and scepticism through which we are now passing. From the nature of things, this is only what might be expected in the case of a remedy for so prevalent and fatal a disease as consumption. Its discoverer claimed for the lymph curative effects only in the early stages, while attempts have been made to benefit cases too far advanced, and as a consequence many deaths are reported. Hundreds of cases of tuberculous affections are now under treatment and observation in the various medical centres of Europe and America, and although it is too early to expect many reported cures, the general consensus of opinion among the observers is that the lymph produces some curative effects and benefit in a majority of cases. It is in lupus that the results of the lymph inoculations are most instructively watched, and it is a noticeable fact that this skin affection has been accepted, with scarcely a dissenting voice, as identical from an etiological point of view with tuberculosis of other organs.

We find published reports in foreign journals of some hundred or more cases of lupus recently placed under treatment by the Koch method. The local changes noted are the same in most instances as those first reported by Koch: that is, there takes place some six to twelve hours after the inoculation, sometimes earlier, a generalized redness and swelling over the affected area, and the tissues become succulent to a greater or less degree. After repeated injections the infiltrated lupus tissue becomes necrotic and is finally thrown off, to be replaced by healthy granulation and cicatrization. Where the lupus is of a superficial variety, with but slight infiltration and thickening, a serous-like exudation takes place after the erysipelatous redness which constitutes the early local reaction has subsided. This is followed by a crusting where the exudation has been marked and by a desquamation in other parts of the lupus patch and sometimes over portions of any cicatricial tissue present which may have resulted from previous treatment or spontaneous healing.

In some cases (Kammerer et als.), after a few injections, an entirely smooth cicatrization of the lupus-affected area can be observed. Such a result in a patient 24 years of age with an extensive lupus of the face is reported from Bergmann's clinic. Injections were begun on the 6th of November, and after three weeks of treatment complete cicatrization had taken place and at the time of the last observation, a week later, no local or general reaction occurred after an injection of 0.05 of the lymph. Dr. Weber (Halle) reports in the *Miinchener Med. Wochen.*, December 23d, 1890, that he saw many cases of lupus treated in Bergmann's clinic, among them being four cases he had himself sent. After inoculation they presented the appearances of patients in high fever. The lupus patches became much reddened, swollen up, hot, and sometimes painful. Red lupus nodules appeared in parts where none had previously been observed. The diagnostic value of the Koch treatment was in such cases very apparent. In one case red lines showed themselves upon the skin, corresponding to lymphatic vessels affected by tuberculosis, which had escaped notice.

In the Leipzig Medical Society Prof. Thiersch reported two children with beginning lupus of the face masked by scrofulous facial eczema, in whom the injection of lymph had produced decided reaction and in fourteen days had effected a cure. In this early stage of lupus masked by an eczema in children with delicate skin the disease was formerly not to be diagnosed, since from the experiments of Karg giant cells are only to be found in already developed lupus nodules; bacilli are present only in the fewest numbers and spores do not take the staining. A number of Karg's microscopical preparations served to illustrate this point. Out of 64 cases treated since November 19th, 12 were of lupus and all had been improved; 3 were tuberculosis of the skin and mucous membrane, 2 of which were improved; 5 were of lymphatic glands, 3 having improved, 1 remaining the same, and 1 cured.

Dr. Thibierge (*Annales de Derm. et de Syph.*, December, 1890) having passed some time in Berlin, gives the result of his observations. At first it was accepted as a fact that lupus cases were promptly cured and cases were discharged, but after a time relapses were found to occur. The dose for lupus is relatively large, Koch advising one centigramme as an initial dose. Intense local reaction usually follows this large dose, and even after one milligramme there may be decided disturbance. He had seen forty milligrammes injected without apparent harm. After falling of the crusts which result from the exudate there is a smooth, regular, rosy-colored tissue found, and a single injection may cause cicatrization of small superficial ulcerations. After all reaction had ceased to follow inoculations the gross appearances indicated lupus nodules still present. Not a single case was seen cured even *in appearance*. Many cases are under treatment at the Saint-Louis Hospital in Paris and will be reported on later.

At a meeting of the Vienna Society of Physicians, January 16th, Prof. Kaposi presented six cases of lupus (*Wiener Med. Presse*, No. 3) which had been under treatment for about six weeks. So great was the improvement which had taken place that those unfamiliar with the disease would look upon them as cured. The skin is entirely flat, nowhere are to be found raised nodules, and no longer are any ulcerations present. No local or general reaction took place in most instances after the third or fourth injection, but inoculations were continued, up to four, six, and eight centigrammes. These cases may be divided into two categories: One in which injections may be

continued in ever-increasing dose, by which means either reaction will finally take place or, in the event of no effect being produced, the treatment for that particular case will be at an end; in the second category there should be an interval of two or three weeks, and then injections should be begun again with small doses. In the mean time the lupus will probably take on renewed action, and it will require a long time before a cure will result. New nodules of lupus may develop, as was the case in one of the patients presented. Since the bacilli cannot escape they advance along the course of lymphatic vessels. It thus becomes necessary to effect their elimination by other means (Paquelin, sharp spoon, etc.). Local treatment will still remain a necessity. It is believed that another six weeks will suffice to permit of a verdict being passed on the new method.

Prof. Billroth has made the same observation in two cases of lupus. One case was sent to the clinic as cured, to have a rhinoplastic operation done. The upper lip was, however, still stiff and infiltrated. After inoculation this infiltration entirely disappeared, leaving behind a slight redness. For ten or twelve days no injection was made, and then only a small dose was given. Decided reaction followed, but subsequent injections failed to produce reaction, though as high as fifteen centigrammes were given.

In a case of serpiginous lupus a violent reaction took place. During the consequent fourteen days' pause the lupus began to develop again. The reaction in this sixteen-year-old patient was, even with five milligrammes, described as "colossal"—a scarlet-like exanthem, temperature of 41° C. and even higher, hæmaturia, etc.

As a contrast to this case, a child was shown with four tuberculous patches on the skin which had not reacted in the least even to as high a dose as fifteen centigrammes. Billroth did not think the period of six weeks set by Kaposi as long enough to determine the value of the method, since the cicatrix, at first elevated and red, takes from a year to a year and a half to become white and atrophic.

At the meeting of the Berlin Surgical Society, January 12th, Köhler reported that since October 11th, 1890, 59 cases had been treated at the Bardeleben Clinic. Three had been discharged as cured and one as improved. The cases in which cure was noted were one of inflammation of the elbow-joint, with fistula of the wrist-joint; one of acute coxitis in a girl of 23; the third does not appear. The case discharged as improved was one of ulcus rodens. One case of hip disease died after seven injections. Solitary tubercles were found in the brain.

As regards dose, a number took as high as thirty milligrammes, a few ninety, and one patient two hundred. Decided improvement was noted in a large number of those treated. Six cases were of skin affections and three of glandular troubles. In a case of rodent ulcer with loss of tissue, beginning at the lower eyelid and extending over the cheek, ear, and nose, no reaction followed the first inoculation. When the bandages were removed five days later nearly the whole surface of the ulcer was healed over, just as after an erysipelas. Subsequent injections produced decided reaction.

Köhler believes the combination of Koch's method and surgical procedures will become more and more frequent.

Muhlack showed two boys with lupus of the face. After twenty-two injections, the dose reaching thirty milligrammes, very decided improvement was to be seen.

Baum reports (*Wiener Med. Presse*, No. 1) two instances of cure, one being a case of lupus of the hand and finger in a young man who had had the affection for four years. Within nineteen days, during which three injections were given, the ulcerations healed entirely and became covered with good, smooth skin. In the second case, a man of 30 who had caries of the bones presented also a large ulcer upon the cheek which had implicated the lower eyelid and caused ectropion. After two injections and within fourteen days the ulcer was healed.

Leloir does not know of any cases of lupus as yet cured. In any event, he believes the methods of cure hitherto employed will not be entirely done away with. One important fact maintained by Leloir for years has been demonstrated by the Koch method—*i.e.*, the tuberculous nature of lupus.

At the last meeting of the Paris Society of Dermatology and Syphilography Vidal reported that since November 32 cases had been inoculated. The general reaction was often quite active, while the lupus patches showed but little change, especially in lupus non-exedens. The dangers were pointed out, consisting in decided congestions in previous healthy organs. Frequent congestion of the bronchi and of the base of the lung. Repeatedly evidences of myo- and endo-carditis had been observed. Enlargement of the spleen was frequent: albuminuria was not rarely discovered, and in three cases hæmaturia had been observed. Four or five days' interval between the inoculations were advised on account of these effects.

R. Köhler showed one case of extensive lupus of the face which had received a total of 730 milligrammes of lymph. Since November 20th there has been no further local reaction, but when, after an interval of two or three weeks, the injections are begun again, the nose shows a suspicious reddening. Healing on the alæ nasi is ideal and the scar remains white in spite of all inoculations. The ulcerated portions of the nose were completely healed after the first injection of ten milligrammes.

The second case had received in all 1,240 milligrammes, the largest single dose being 110 milligrammes. Since November 3d no further reaction. No exudation occurred here, but simply redness and desquamation. Here and there are still diseased points which must be treated surgically or by further injections. In all events, these two cases show that lupus areas can without surgical aid be brought to heal by the Koch method. Socin (*ib.*) reports upon twenty cases of surgical tuberculosis. One of *lupus exfoliativus et exulcerus faciei* of sixteen years' standing healed nearly completely in four weeks after six injections of one centigramme each. Three injections of the same dose produced healing of all the ulcers in a case of lupus of both cheeks and the nose. Other cases of lupus showed decided improvement.

Dr. Williams (*British Med. Journal*, January 3d) reports a case of lupus of the face which had existed for fifteen years, and after ten injections, extending over three weeks, the improvement was so great that a complete cure was to be hoped for. Colored pictures which accompany the article show the condition before treatment, during reaction, and three weeks after beginning of treatment. CHARLES W. ALLEN.

Lupus Vulgaris treated with Koch's Lymph. Death Thirty-six Hours after an Injection of Two Milligrammes.

This is the first, or about the first, death reported from the use of Koch's lymph in a case of lupus. Prof. Jarisch reports it in *Wien. klin. Wochen-*

schrift, 1890, iii., 972. It was a severe case of lupus of the face of long standing in a strumous young woman. It had been treated by various plans. Normal chest and abdominal organs. The first injection was made on the 3d of December. Every precaution was taken to prevent complications. Two milligrammes were injected according to Koch's method. Four other patients were treated in the same way and with the same fluid without any reaction beyond what was anticipated. In the unfortunate patient, on the afternoon of the injection somnolence set in. On the next morning the pulse could not be counted, and in spite of every effort the patient died in the evening of heart failure. The autopsy showed pneumonic infiltration and œdema of both lungs; œdema of brain and spinal cord; acute swelling of a chronically enlarged spleen; and slight degree of parenchymatous swelling of the liver and kidneys. Capillary hemorrhages of the pleura, pericardium, thymus, and spinal cord. The classic effects upon lupus tissue as described by Koch were also found, as well as lesions of the intestinal canal.

GEO. THOS. JACKSON.

Solutio Calcii bisulfurosi as used in Unna's Clinic. (BERLINER in *Monatshft. f. prakt. Derm.*, 1890, XI., 367.)

This contains 5 per cent of free sulphuric acid and is used combined with lanolin and lard or vaselin, to form two ointments. The first is composed of sol. calcii sulfurosi, 40 parts; adeps, 20 parts; and lanolin, 10 parts. It contains 3 per cent of free sulphuric acid and has its peculiar odor. The second ointment has 10 parts of sol. calcii sulfurosi and 20 parts each of lanolin and vaselin. It contains 1 per cent of free acid and is odorless. It acts very promptly in chromophytosis, and proved exceedingly useful in one case each of diffused inveterate psoriasis and vesicular moist eczema.

GEO. THOS. JACKSON.

Furunculosis. VEIEL, of Cannstatt. (*Monatshft. f. prakt. Derm.*, 1890, XI., 362.)

According to the author, the treatment of furunculosis must be conducted in one or more of the following ways, viz.: 1. To destroy the pus cocci by antiparasitics before they have caused necrosis of the tissues. 2. If necrosis has already begun, the separation of the necrosed cone with its pus cocci must be hastened as much as possible. 3. To prevent the formation of new furuncles by infection by the pus cocci of suppurating furuncles. 4. To put the constitution in the position of greatest resistance to the invasion by the pus cocci. The first indication can be met only in a few cases. When the case is seen it has advanced so far that antiseptics applied to the skin cannot penetrate to the bottom of the glands and attack the cocci. Boring into the furuncle with 3% carbolic acid solution, or nitrate of silver, or the bichloride of mercury paste pencil of Unna meets the indication better, but the procedure is so painful and uncertain that it can be employed only in the case of single furuncles. We have therefore to depend upon the second method, and for this there is nothing better than the old-fashioned, but of late condemned, poultice. They must be continued until the last furuncle has disappeared. Infection of surrounding parts can be avoided to a large extent by the observance of cleanliness, and by brushing the surface of the poultice and the skin with a one-per-cent sublimate solution, or, in irritable skins, with a four-per-cent boric acid solution. During the night the furuncles are to be covered

with a paste of equal parts of zinc oxide and vaselin, with four per cent of boric acid, spread thickly on lint and bound down with plaster. Only very slowly developing furuncles should be opened with a knife, and the contents of none should be early squeezed out. The above-mentioned paste fully meets the third indication for treatment, and is unsurpassed in general furunculosis when its application is renewed three times a day. Corrosive sublimate baths greatly supplement the treatment if the patient's skin will bear them. Great personal cleanliness and avoidance of scratching are other adjuvants. As to the fourth indication, it must be fulfilled on general principles. Arsenic and sulphide of calcium are useless, and cathartics do harm.

GEO. THOS. JACKSON.

Chronic Ulcers Treated by Massage. MR. HERBERT. (*Brit. Med. Jour.*, 1890, II., 1362.)

The author reports excellent and speedy results from having the patients knead and rub the thickened skin about their ulcers for half an hour twice a day. Simple dressings are to be used in the mean time.

GEO. THOS. JACKSON.

The Influence of Clothing on the Skin. DR. J. L. FOLEY, of Montreal. (*Montreal Med. Jour.*, 1890, XIX., 406.)

This is the title of a rather remarkable essay. After enumerating various articles of clothing which he deems active in producing skin diseases, he gives the following "Rules as to Clothing in Skin Diseases." It is the inside rather than the outside clothing that mostly affects the skin. If the disease be chronic and indolent, flannel shirts and drawers may be worn next the skin; if irritable and inflammatory, soft and frequently-washed old cotton. In acute and subacute eczema the bedclothes should be as light as possible. The clothing should never be rough enough to irritate the skin; should be free from all poisonous dyes, properly washed, and frequently changed. All restriction and constriction must be avoided. In tinea tonsurans all woollen clothes should be discarded; flannels should be avoided in tinea versicolor, pruritus, and seborrhœa corporis, and silk worn instead. In itching of toes stockings should be changed often and broad and easy boots and shoes worn. In chilblains the underclothing, stockings, and gloves should be of woollen and warm, and cork soles should be worn inside of the shoes. In miliaria, sudamina, urticaria, and hyperidrosis the clothing should be light. In erythema multiforme silk or soft linen should be worn. In eczema it is well to use protectives to keep the clothing from rubbing the skin, and if the patient is confined to bed to have the bedclothes raised away from the diseased part.

GEO. THOS. JACKSON.

Persistent Dandruff, Acne, and Seborrhœa of Unna. DR. E. BLAKE. (*Lancet*, 1890, II., 1376.)

The author concedes that dandruff is contagious and parasitic. His theory of seborrhœa is that a person becomes dyscrasic and at the same time has a feeble heart action. In this state the sebum becomes thickened into a solid fat, the orifice of the follicle becoming blocked up with it and the accumulated epithelial cell débris. This forms a nidus for the microspore, which declares its presence by the pruritus it sets up. Degenerated epithelium cells are proliferated, and after a time no more sebum is produced. Then the hair grows dry, harsh, and brittle, and soon breaks off on account of the pressure

of accumulated epithelial cells in and near the mouth of the sebaceous gland. The epithelial cells continuing to accumulate soon plug up the hair follicles and protrude as little papules, and from their being broken up in scratching proceeds the dandruff. For the treatment of the disease the head should be well washed with hot water and alcohol soap. This is then washed off and the head dried. Then the head should be anointed with glycerole of tannin, of the strength of ten to thirty grains to the ounce. If tannin fails try resorcin. Repeat applications once to three times a week. After the dandruff is removed dress daily with carbolic acid, 10 grains; oil of cinnamon, 1 drachm; and olive oil, 1 ounce.

Two cases are cited of acne of the back with dandruff of the scalp, both of which got well under purely local treatment for dandruff. He seeks to show that the acne was produced by contagion from the dandruff.

GEO. THOS. JACKSON.

Lupus Vulgaris. DR. BROOKE. (*Monatshft. f. prakt. Dermat.*, 1890, XI., 377.)

Some cases may be successfully treated by the use of this ointment: Hydrarg. oleatis vel olein (2½–5%), 30; acidi salicylici, 0.7 to 1.0.; ichthyol, 0.5; ol. lavendulæ vel ol. citronellæ, q.s. He uses it most in lupus cases that shun an operation, and has been surprised at times at its curative effect. If it proves too strong so that the skin cracks or becomes excoriated, the strength must be reduced or a three-per-cent ointment of carbolic acid in ungt. zinci oxidi substituted. The best method of using the ointment is by rubbing it in for twenty minutes at night and ten minutes in the morning. Powdering corn starch over the greased skin will be agreeable to the patient.

GEO. THOS. JACKSON.

Action of Guaco in Pruritic Affections of the Skin. DR. BUTTE. (*Annales de Policlinique de Paris*, Nov., 1890.)

In a very interesting study of the physiological and therapeutical action of the aqueous extract of guaco, Dr. Butte gives the results of his experiments with this drug in the treatment of various cutaneous affections. Physiological experimentation has demonstrated that the action of the extract of this plant is to paralyze the nervous centres of sensation, and clinical observations prove that the disappearance of the painful sensations in certain pruriginous maladies may result from the application of a decoction of guaco upon the cutaneous surface or its absorption by the digestive tract. The use of this drug is especially indicated in cutaneous affections in which pruritus is a dominant symptom.

A number of cases are detailed of various forms of pruriginous eczema and of arsenical cutaneous pruritus in which prompt amelioration of the burning and itching sensations followed the external use of the guaco decoction. It should not, however, be employed in acute weeping eczemas, since it exercises an irritant action upon the inflamed surface. In the treatment of general pruritus without cutaneous lesions its influence in suppressing the sensations of itching is most marked. It may be employed externally in the form of a decoction according to the following formula: Crushed guaco, 30 gm.; bicarbonate of soda, 5 gm.; water, 1,000 gm. Boil for a quarter of an hour, macerate an hour, decant, and employ warm, either in lotion or by compresses saturated in the solution. Internally it may be given combined with benzoate of lithium in a syrup of bitter orange peel or in pill form as

follows: Aqueous extract of guaco, 10 gm.; bicarbonate of sodium, 0.05 gm. M. s. a. For one pill. Take two pills immediately after each meal.

Multiple Epitheliomata of the Face; Erysipelas with Consecutive Retrogression of the Epithelial Growths; Absence of Glandular Affection. DR. RODOLFO STANZIALE. (*Gazetta degli Hospitali*, XI., No. 74, 1890.)

The patient, a woman, was 43 years of age and married. She had a weak frame; normal musculature. The adipose tissue was scant. She was badly nourished, had a pallid skin and anæmic mucous membranes. At the right temporo-frontal region an extensive solution of continuity was to be seen, which rested upon a very much infiltrated base, with serpiginous and exuberant edges. The growth was of a dark red color, bled easily; it possessed thickened and elevated edges and secreted a sanguino-serous, purulent fluid. A little below this, as well as on some other places of the face, one detected cicatricial tissue of recent origin. In other parts of the face, as at the right malar region, the right naso-labial sulcus and right ala nasi, and at the left lachrymal region, the cheek and temporo-frontal region of the same side, ulcers were noticed. These latter were of various sizes, had an elevated base, were granulomatous, red in color, easily bleeding, with purulent secretion. The same process took place on the upper lip, which was affected in its entire medium portion.

In several places on the face, and also on the sternum, multiple seborrhoic verrucæ were present. The glands were not affected. On the 3d of April, about two weeks after the entrance of the patient into the hospital, an erysipelas of the right side of the face developed, which lasted for eighteen days and invaded, gradually, the whole face. After the disappearance of the erysipelas a perceptible retrogression of the epithelial neoplasms took place.

PICK AND PRITCHARD.

The Female Urethra: A Source of Trouble Often Overlooked in Our Gynæcological Investigations. DR. K. P. MOORE. (*The Atlanta Medical and Surgical Journal*, Vol. VII., Sept., 1890.)

The author's patient, aged 48 years, had suffered for years, and now when she came to him was a nervous wreck. Previous well-conducted gynæcological treatment had failed to restore health. The author, after protracted search for any cause sufficient to account for his patient's deplorable condition, discovered hid away in the inferior floor of the urethra, just within the meatus, two papillary angiomata not larger than a very small pea. The author treats this condition by the most thorough excision with the knife, and the cauterization of any base or stump, to escape the risk, which is always to be kept in mind, the proneness of papillary angiomata to return.

Book Reviews.

Wood's Medical and Surgical Monographs. July, August, September, and October Numbers, 1890. Wm. Wood & Co., 56 Lafayette Place, New York.

Since our last notice we have received the above numbers of this periodical publication of original treatises, books, and monographs selected from the latest literature of foreign countries. These numbers fully sustain the repu-

tation of the series. Excellent judgment has been shown in the selection of material, which embraces a large number of subjects sufficiently diversified to meet any variety of taste. The authors are writers of well-known ability and of international reputation.

The July number opens with a monograph on Stricture of the Rectum, by Chas. B. Kelsey, M.D. Other titles are The Influence of Heredity in Alcoholism, by Dr. Paul Sollier; Rabies, by Louis Pasteur; Colotomy, by Thomas Bryant, F.R.C.S.; Massage of the Abdomen, by Dr. Rubens Hirschberg.

The August number contains A Treatise on Morbid Blushing: its Pathology and Treatment, by Harry Campbell, M.D.; Alcoholism in Women, by Dr. Thomeuf; The Different Methods of Lifting and Carrying the Sick and Injured, by George H. Darwin, M.D.; Treatment of Ingrowing Toe-nail, by Joseph Amiard, M.D.; Chronic Bronchitis and its Treatment, by William Murrell, M.D.

The September number contains a monograph on Insomnia and its Treatment, by A. W. Macfarlane, M.D., with the index for Vol. VII.

Contents of the October number: Suppurative and Septic Diseases, by W. Watson Cheyne, M.B.; Pharmacopœia for Diseases of the Skin, by James Startin; The Nasal Neuroses, by Granville McDonald, M.D.; Artificial Respiration, by Benj. W. Richardson, M.D.; The New-Born Infant: its Physiology, Hygiene, and Nourishment, by Dr. A. Auvard; The Urine in Neurotic Diseases, by Dr. Alexander Peyer.

Transactions of the American Dermatological Association. Fourteenth Annual Meeting. Official report by GEORGE THOMAS JACKSON, Secretary.

The official publication of the "Transactions of the American Dermatological Association" at its fourteenth annual meeting, held at Richfield Springs, N. Y., on September 2d to 4th, 1890, has been received by us. An abstract of these proceedings appeared in the November number of this JOURNAL. It forms a neat pamphlet of sixty pages. It begins with a list of the active members of the association. We would commend this list on account of the names of the members being given in full, a feature that, we think, should be adopted in all official lists of names. The address of the president, Dr. P. A. Morrow, occupies some ten pages, and concerns itself principally with a study of the condition of dermatological instruction in this country at the present time. He gives due credit to the work of the American Dermatological Association in building up this special branch of practice, and shows the flourishing condition of dermatology in America. His fear is that the popularization of the specialty has gone too far, and that there is great danger of medical students being inadequately, if not improperly, taught by some of the eighty-six instructors in skin diseases, on account of the necessary paucity of clinical material in the smaller cities.

Abstracts of the papers read at the meeting and full reports of the discussions upon them form the bulk of the volume. We find that papers were read by Drs. Bronson, Taylor, Jackson, Allen, Klotz, and Ransom, of New York; Bowen and White, of Boston; Stelwagon and Duhring, of Philadelphia; Corlett, of Cleveland; and Shepherd, of Montreal.

The volume ends with a list of the publications of the members of the association during the two years ending September 1st, 1890, last year's list having been omitted from the volume preceding this one.

FIG. 1.

FIG. 2.

DR. ERONSON'S CASES: ACNÉ VARIOLIFORMIS OF THE EXTREMITIES (FIG. 1); FOLLICULITIS DECALVANS (FIG. 2.)

FIG. 1.—A BEGINNING PAPULE IN ACNE VARIOLIFORMIS SHOWING THE SMALL-CELL INFILTRATION ABOUT THE SWEAT GLANDS.

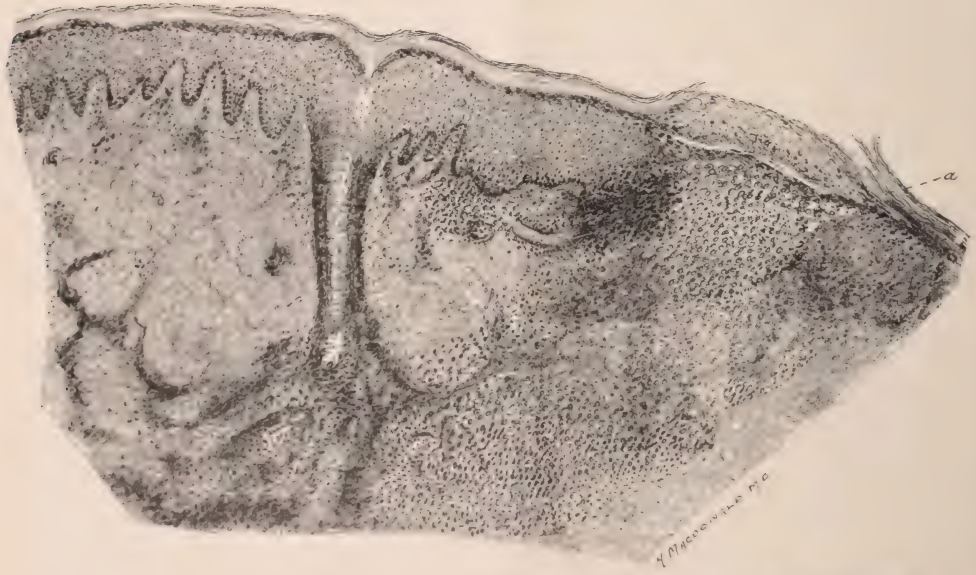

FIG. 2.—A PAPULE IN ACNE VARIOLIFORMIS AT AN ADVANCED STAGE, SHOWING THE CELL INFILTRATION AT THE SIDE OF THE HAIR FOLLICLE, AND THE BREAKING DOWN OF THE EPIDERMIS AT *a*.

FIG. 3.—A PAPULE IN ACNE VARIOLIFORMS AFTER THE FORMATION OF THE CENTRAL NECROTIC MASS *a*. THE SITUATION OF A SMALL ABCESS CAVITY IS SHOWN AT *b*.

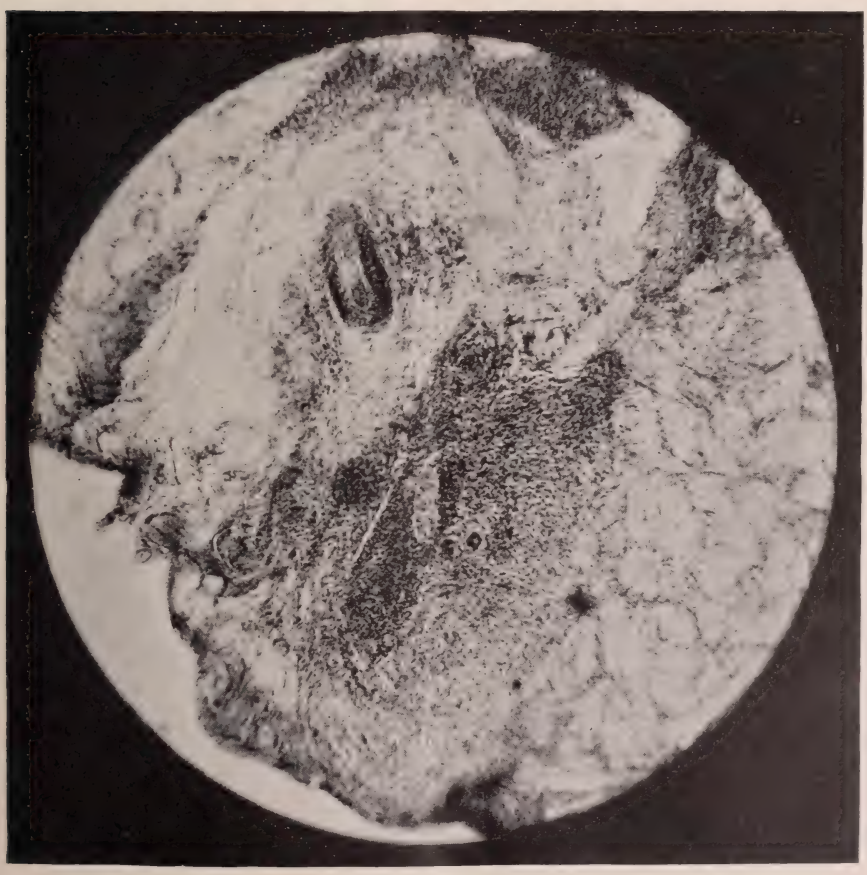

FIG. 4.—PHOTO-MICROGRAPH SHOWING A BEGINNING PAPULE IN ACNE VARIOLIFORMIS.

Fig. 1.

Fig. 2.

Fig. 3.

Fig. 4.

Fig. 5.

Fig. 6.

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NOTES ON CERTAIN PUSTULAR DISEASES ATTENDED WITH ATROPHY.

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ACNE VARIOLIFORMIS OF THE EXTREMITIES.

ON the 26th of October last, the following note was made concerning a patient (see Plate, Fig. 1) who came to the Out-Door Department of the Polyclinic. At the first examination, on account of the location and the unusual aspect of the disease generally, a positive diagnosis was not made. The affection which at first it seemed most to resemble was acne cachecticorum, but the case lacked all other symptoms of cachexia, and, moreover, the eruption seemed too circumscribed for that disease. The diagnosis acne varioliformis was finally arrived at as much by exclusion as by strictly affirmative features.

G. K., aged 20, native of Germany; piano-finisher by trade. Both family and personal history, so far as could be ascertained, good. The present disease began two or three months ago, first on the backs of the hands, thence extending up the arms, and afterward appearing on the feet and legs. The general features of the eruption have been from the first the same as at present. The disease began without constitutional disturbance of any sort so far as the patient is aware, and during the entire period his general health has been good.

Status præsens.—The patient, though not robust, does not appear especially delicate; is well developed and seems well nourished. The cutaneous affection is his only complaint, and from this he suffers no annoyance except from its appearance. It occupies both the upper

and lower extremities, and consists of discrete, grouped efflorescences, partly papular, partly pustular, and partly crusted, and varying in size from miliary to lenticular. On the upper extremities the eruption occurs symmetrically on the backs of the hands and wrists, thence curves around to the ulnar aspects of the forearms, extends up over the elbows, and on to the backs of the upper arms as far as the junction of the lower with the middle third of the humerus. The efflorescences are for the most part grouped and are very abundant. Their general color is a brownish-red, in places looking not unlike a lenticular papular syphilide. The most recent of them are small or miliary papules that seem moderately deep-seated and have a slight shotty feel. They seem afterward to become vesicular or vesiculo-pustular, growing in size till lenticular, the vesicle enlarging but never becoming prominent. In places, especially above the elbows, the vesicles or vesico-pustules resemble those of varicella, but are flatter, less full. As the efflorescences increase in size the inflammation shows more, and in places they are attended with considerable areola. Most of them are in the stage of desiccation, are flattened, dark colored, and a majority of the spots are covered with thin, depressed, dark or blackish crusts. On many others the crusts have disappeared, leaving round, depressed, and more or less pitted cicatrices; some of them dark red in color or deeply pigmented; others white, apparently according to their age. These cicatrices vary much in size. The majority are about as large as large pinheads: some, but few, are the size of lentils or small split peas. The distribution of the eruption was almost absolutely confined to the regions above mentioned. The anterior surfaces of the hands and forearms, as well as the radial aspects of the latter, were almost entirely free.

On the lower extremities the eruption occupies the dorsal surfaces of the feet (including a few efflorescences upon the toes), the entire circumference of the ankles, extends up the back of the legs; a few occur over the anterior aspects of the knees, and one or two above the knees on the front and lower part of the thighs. In its general character the eruption here is about the same as upon the upper extremities. The spots are grouped together, are papular and deep-seated at first, then vesiculo-pustular, and leave cicatrices. Some of the lesions are more inflammatory, however, than on the hands and arms, and are surrounded by more marked areolas. Other parts of the body than those mentioned are entirely free from the eruption. On the face there is some acne pustulosa with comedones, but nothing resembling the eruption on the extremities. The latter seems to cause the patient no discomfort. There is neither itching nor pain unless the inflamed spots be roughly rubbed or manipulated, when there is some feeling of soreness.

Such was the note made of this case shortly after it was first seen. The treatment adopted was based on the assumption that the disease had a parasitic origin, and the patient was directed to apply twice a day a lotion consisting of 0.4 per cent solution of the bichloride of mercury in a saturated alcoholic solution of boracic acid. This appli-

cation apparently effected a cure in a few weeks. At the end of a month the old efflorescences had all healed and no new ones appeared.

As to whether this disease was identical with the acne frontalis of Hebra and the acne varioliformis of Kaposi, the writer anticipates a difference of opinion. Certainly it did not in all of its features conform to the latter affection, more particularly in the location and in the amount of pustulation, as well as in its disposition to heal. But it is a generally-recognized fact that this affection may occur in other situations than on the face, and that the suppuration is a purely secondary and non-essential matter dependent on accidental and extraneous causes. Moreover, in most of the lesions in the above case the pustules were insignificant. The main features were the deep-seated papules, the early formation of the depressed, dry (or "mummified"), closely-adherent crusts, and the resulting atrophy of the affected spots. Whether the follicles were the essential seats of the disease could not be easily determined from the clinical appearances. In some instances the papules or pustules apparently occupied the sites of the hair-follicles, but not in sufficient number to be conclusive as to any essential connection. But it is by no means certain that the acne frontalis of Hebra is a follicular disease. Indeed, there are serious reasons why it should not be regarded as an acne at all. There is certainly no evidence of steatosis, as in acne vulgaris, and microscopists differ in opinion as to the essential seat of the disease. In certain typical cases the uniformity of the clinical features, especially when the affection occurs in its most frequent situations—viz., at the borders of the hair on the forehead and temples—the diagnosis is not difficult; but what divergences from this well-known type are yet consistent with the diagnosis it is hard to determine, and will be till better criteria of the disease are known than those we possess at present.

In 1885 Grunewald[1] described an alleged case of acne varioliformis in which the lesions were distributed over the entire body, and which had a fatal issue. Professor Köbner and Dr. Lassar are cited as vouching for the correctness of the diagnosis. Boeck,[2] under the designation acne frontalis seu necrotica, describes a gangrenous form of this disease occurring upon the trunk, having been preceded by an eruption of the disease in its typical form upon the face. He also refers to Grunewald's case, but disputes the diagnosis.

Pick[3] describes a case of typical acne frontalis seu varioliformis occurring not only on the face, but also on the neck, the backs of the hands, and the forearms. He also describes a case corresponding to

[1] Monatshf. f. prakt. Dermatol., iv., 1885, p. 81.

[2] Arch. f. Derm. u. Syph., 1889, p. 37.

[3] Arch. f. Derm. u. Syph., 1889, p. 551.

the acne necrotica of Boeck, though he disputes the identity of this affection with the acne varioliformis of Hebra. Whatever be its nature, however, it would seem to be more nearly related to the latter than to any other recognized form of dermatosis. Perhaps a similar relation might be claimed for a curious case that came under my observation some nine years ago. It is not presented as a case of acne varioliformis, but as possibly an allied affection. It was entered in my notes with the designation "acne atrophica with ulceration." The term acne was no more and no less applicable to it than to the cases just described. The case is the following, which I may call provisionally

ACNE ULCERANS.

Mrs. F., aged 40, married and the mother of two healthy children, is a woman of delicate build and rather low vitality. Has always been a dyspeptic, feels bloated after meals, disposed to constipation, and never knows what a good appetite is; suffers habitually from depressed spirits. Says that since she was fourteen years of age she has never been free from eruptions on the face that have always annoyed her, and she is especially distressed by that from which she suffers now. When first seen by me in 1882 it consisted of disseminated acuminated red papules (less than half a dozen) scattered over the face. They contained no comedones, but usually a minute quantity of matter at their apices. After lasting some weeks they disappear, leaving superficial depressed scars. While they last they "prick," and the patient is much in the habit of scratching or pinching them. The scars left are abundantly distributed over the face, most of them not larger than millet-seeds. Some few are considerably larger. Occasionally superficial ulcerations would form. Once it was noted that on the right temple there is an irregular superficial ulcer or abrasion that looks much like the surface of a slight burn or scald that had destroyed the upper layer of the skin. It is about three-quarters of an inch long by one-quarter inch wide, with an irregular outline. The surface is depressed, pale, but readily bleeds. The edges are not thickened nor infiltrated in the slightest degree, nor is there any areola. On the left temple a smaller, red, slightly-depressed cicatricial spot shows where a similar lesion has healed. On the forehead, chin, cheeks, and neck, especially the nape, there are a number of whitish or pigmented scars of an irregularly-rounded shape, and average about the size of a lentil. Together with these are a few miliary papules, some of them slightly purulent. Where the lesions are most numerous there is a brownish mottling of the skin from pigmentation. The lesions continued to recur for several years, during which the patient was seen at infrequent intervals. At one time in 1886 there was a very persistent crop of the ulcers or abrasions just under the angle of the chin on the left side. A place an inch long by a half to a quarter inch wide; of irregular oval shape, lasted for a period of several weeks. It was smooth,

dry, and of a beefy-red color. Here and there were little bloody crusts. It was slightly depressed; the edges were thin, a trifle puckered, and without infiltration. Had the usual tormenting pricking sensation, as if a foreign body were in it. Further back, along the ramus of the jaw, were two or three pin-head-sized or larger spots, also excoriated. Similar excoriations occurred on the scalp over the temples; one that was cup-shaped at first, looking as though a bit of skin had been gouged out, lasted for a month or more, extending slowly in a serpiginous way, and destroying the hair over a space a half-inch long by a quarter wide. The hair afterward grew again, however. These excoriated spots had not the appearance of an eczema. There was never any crusting and no thickening. Nor was the epidermis in the vicinity affected as in eczema. The lesions remained stationary much longer than would eczematous erosions. Moreover, eczema would not account for the scarring. So far as could be ascertained, the ulcerating lesions invariably began as little papules which were eroded by scratching, but instead of healing took on a serpiginous action that would then persist for weeks or months. By the use of caustics its progress could usually be arrested. From a report received from the patient's family physician recently, it was learned that the disease was still in progress.

"Folliculitis Decalvans."

Within a few years past French dermatologists have called attention to certain peculiar and hitherto undescribed forms of alopecia attended with follicular, often pustular, inflammation and cicatricial atrophy of the affected parts. Thus Quinquaud, under the title "*Folliculite des régions velues*," [4] described what he terms a "*folliculite épilante ou décalvante*," that usually occurred upon the scalp, but sometimes upon the region of the beard, of the axillæ or the pubes, and was characterized as follows: "The patches of alopecia that it causes are irregular and not exactly circular, almost smooth or polished, showing at the periphery certain granular elevations. The skin is decolored, white and atrophic, showing in places a slight redness. The patches are disseminated, of the size of a franc piece, separated by grayish islets of normal skin, with tufts of hair offering the normal resistance to epilation. By the eye alone, as well as with a magnifying glass, a depression of the skin with pseudo-cicatricial appearance is plainly to be seen. The fundamental characteristic of the lesion is the existence at the periphery of the patches or in the islands of sound skin of follicular lesions of varying aspect; most commonly there are purulent spots like miliary abscesses of the size of pins' heads or merely punctiform, with a hair in the centre of each that can with ease be with-

[4] Bulletin de la Société Médicale des Hôpitaux, Août, 1888. Annales de Derm. et de Syph., 1888, p. 657.

drawn with the pinchers or that falls out spontaneously. The fall of a series of neighboring hairs produces large patches of alopecia of a pseudo-cicatricial character." The affection, it is said, is often of long duration, occurring in successive acute attacks at first severe, later more light. Microscopic examination of the follicles revealed the presence not only of the streptococcus pyogenes, but also there was found a micrococcus under the form of monococcus, of diplococcus, and in series of fours existing in the hair-follicle as well as in the blood from the inflamed region. Cultivations of this micro-organism were made from which successful inoculations were effected upon the skin of rats, mice, and rabbits, with the production of follicular lesions and loss of the hair.

Brocq,[5] in discussing "*des folliculites et des périfolliculites décalvantes*," differentiates four clinical varieties. In the first, which he terms "*pseudo-pelade*," the manifestations of inflammation are very slight, without pustulation, and show only a slight tumefaction and redness about the affected follicles. The second is said to correspond to Quinquaud's disease. The third, which he terms "*sycosis lupoïde*," is said to resemble a parasitic sycosis, but differing from it in its tendency to extend regularly at the periphery and in the production of thick, keloidal cicatrices. The fourth variety is regarded as identical with the "dermatitis papillaris capillitii" of Kaposi.

The third of these varieties corresponds more or less closely to a case described by Besnier[6] under the denomination "*alopécie cicatricielle innominée*," and which differs from the affection described by Quinquaud chiefly in the continuous and chronic character of the disease (instead of recurring in successive more or less acute attacks), in the superficial pustulation which did not deeply invade the hair-follicles, and in the more decided atrophic changes in the skin. The patient was a man 36 years of age, and the disease had existed for about a year. The condition is described as follows: "The whole posterior part of the hairy scalp, from the middle of a bald spot [alopecia præsenilis] on the top of the head to the occipital protuberance and laterally to the temporal regions, is thickly set with patches of alopecia of irregular form and dimensions, spreading in a serpiginous manner, with smooth, hard, depressed centres, and completely bald. At the periphery of these patches the borders are ill defined and merge gradually into the islands of sound skin; between the islands and the centre of the patches the scalp is bald, irregularly reddened, showing occasionally hairs broken at the *niveau*, little collections of pus occupy-

[5] Annales de Derm. et de Syph., 1889, p. 467.
[6] Annales de Derm. et de Syph., 1889, p. 104.

ing the infundibula of the hair-follicles, but superficial and precisely like what is observed at the beginning of recrudescence in cases of favus. Some points a little excoriated by scratching resemble the most superficial lesions of acne pilaris. Nowhere is there anything like nodosity, veritable folliculitis, kerion, nor sycosis." Treatment seemed to have little or no influence on the disease. Quinquaud had employed nitrate of silver and solutions of biniodide and bichloride of mercury in his case with successful results.

A case that would seem to belong to the class of diseases just described, whatever be their correct designation, is the following (see Plate I., Fig. 2):

T. R., aged 20, a native of Ireland, laborer, was admitted to Charity Hospital in the early part of September, 1890. The patient's general health was apparently good, and his only complaint was a disease of the scalp, which he stated had existed for ten years. It began upon the vertex as a small itchy spot and gradually extended, with more or less crusting and loss of the hair. The crusts, so far as could be learned, were usually associated with moist exudation, and have generally been of the same character as at present. Is not aware that any other persons with whom he has associated have had a similar affection. On his entrance to the hospital the entire crown of the head was covered by dirty, moist granular crusts, and the general appearance was that of an impetiginous eczema, excepting for the numerous patches of alopecia. On removing the crusts the entire upper portions of the scalp were seen to be more or less diseased. There was, here and there, some evidence of eczema, but far less than had been expected. The most striking thing was the abundance of cicatricial tissue. Extending from the forehead to the occipital protuberance, and laterally just over the parietal prominences, the scalp was almost everywhere atrophic, with hairs growing in irregular tufts or patches between with numerous small pustules scattered over the whole surface. The latter were for the most part superficial, though many of them rested on prominent conical miliary or lenticular papules which occupied the sites of hair-follicles. The hairs that emerged from the inflamed follicles could be epilated with very slight traction. Generally the pustules appeared most numerous at the periphery of the atrophic patches, where they were usually conical, though many, and especially the more superficial ones, were irregularly distributed over the general surface. The appearance of the scalp was not unlike what is often seen after long-continued favus. But of this disease no other evidence could be discovered. During a three-months' stay in the hospital nothing like favus scutula appeared, and no achorion Schönleinii was found in spite of repeated microscopic examinations. At first the surface of the affected scalp was much reddened, but with emollient treatment this disappeared, while the atrophy and the follicular inflammation became the more striking. Applications of a solution of the bichloride of mercury (grs. ij.: ℥ i.) seemed for a time, toward the end of the first month,

to hold the pustulation in abeyance, but successive crops continued, though in less degree, to recur, until at his own request the patient was discharged from the hospital.

A case more closely resembling the affection described by Quinquaud has been observed quite recently—that is, within the past four months.

A lady, 50 years of age, had suffered from the disease for three years. Upon the vertex of the scalp was a spot of alopecia two and a half inches in diameter. At the periphery of this successive crops of small, slightly-elevated pustules occurred, each occupying the site of a hair-follicle. The pustules occurred in closely-aggregated groups, sometimes on one side of the bald patch, sometimes on another, each succeeding crop extending a little farther into the surrounding area of the normal skin. As the pustules dried up the hairs dropped out, and a dusky red lenticular papule was left that gradually subsided, leaving a little depressed atrophic spot. Twice the disease has been apparently healed by the application of a solution of the bichloride and has again recurred.

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MICROSCOPIC EXAMINATION IN DR. BRONSON'S CASE OF ACNE VARIOLIFORMIS OF THE EXTREMITIES.

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THE microscopic examination in the foregoing case of acne variolifornis of the extremities was made from three papules removed by the cutaneous punch from the dorsum of the hand and from the posterior aspect of the forearm. The papules when freshly excised were from four to five millimetres in diameter, and included the entire thickness of the skin with a portion of the subcutaneous tissue. To determine, if possible, the anatomical structure of the derma from which the papules originated, one of them was removed in an early stage of development while situated deeply below the surface, and felt as a firm subcutaneous papule, probably a millimetre in diameter. The epidermis over this papule was unaffected and not appreciably elevated, but the deposit could be readily seen and felt.

A second papule was excised while in a more advanced stage of development, being larger and of a darker hue; the epidermis over it had undergone some change and appeared slightly elevated.

A third papule was removed at a stage corresponding to the complete evolution of the pathological process, its central necrotic mass having almost completely separated itself from the subjacent tissue, while surrounding it a marked inflammatory zone was present.

In the process of excision a small abscess at the side of the slough was evacuated, the situation of which is shown in the drawing (Fig. 3). Sections from this papule included the central necrotic mass as well as the surrounding zone of inflammation. The excised papules were hardened in alcohol, imbedded in celloidin, cut with a Thoma microtome, stained in a variety of ways, and mounted in balsam. The most satisfactory results were obtained from hæmatoxylin alone, and a double stain of hæmatoxylin and eosin, or picrocarmine.

Examination of a Subcutaneous Papule in an Early Stage of Development.—Sections from this papule examined under a low power show few changes in the epidermis. The horny layer is everywhere of pretty uniform thickness and firmly adherent. The stratum granulosum is well defined, and contains from four to five layers of cells rich in keratohyalin. The rete Malpighii is unchanged. The blood-vessels of the papillary and sub-papillary regions are dilated and surrounded in places by small round-cell infiltration, but there is no tendency in these regions to the formation of nodules as seen in the deeper portions of the cutis.

In a number of the sections longitudinal views of sweat-ducts were encountered, surrounded, with their accompanying blood-vessels, by small exudation cells.

Longitudinal and oblique sections of hair-follicles, with their inclosed hairs, were also seen unchanged and not the seat of a perifollicular exudation. In a few sections the hair-follicle, with its sebaceous gland, could be traced throughout its entire length quite unaffected. In the deeper layers of the derma oblique sections of the hair-follicles were often seen surrounded by small exudation cells. The perifolliculitis in these cases appeared to be secondary, however, as it occurred generally at the periphery of a deep-seated nodule where the inflammatory action was intense, seemingly involving all the tissues of the cutis alike at this place.

The most striking features of the section under a low power were the presence of deep-seated, irregularly-rounded foci of inflammation at the situation of the coil glands, and encompassing these glands in a dense mass of small round-cell infiltration (see Fig. 1, and Fig. 4). Two of these small nodules were especially well marked in the lowermost portion of the section, lying to the right and left of the median line, while between them was a poorly-defined mass of small cells, which were not readily colored with hæmatoxylin. Scattered among the cells of

this central mass, granular matter and disintegrating cells could be made out. It was difficult to determine whether the apparently separate foci of inflammation had occurred at the same time, forming a single nodule the centre of which was undergoing retrogressive changes or whether they originated independently.

I am inclined to the latter view, as portions of unaffected cutis were visible between the nodules. The most intense inflammatory action was certainly present about the coil glands, as revealed by the greatest number of small round cells at these situations. A direct relationship between these glands and their surrounding inflammation could not, however, be made out, as they were apparently unaltered in their histological structure. Their lumen was unchanged and the nuclei of their lining cells were readily stained with hæmatoxylin and borax-carmine.

A sweat-duct could frequently be traced from one of the deep-seated nodules to the epidermis, surrounded by small round cells.

In over fifty sections examined from this papule the hair-follicles were found unaffected in their superior portions. A perifolliculitis was only present, as before stated, in connection with the deep-seated inflammation. The sebaceous glands were found in every instance to be quite normal.

Examination of a Papule at a More Advanced Stage of Development.—In sections from this papule the cutis, instead of presenting sharply-defined groups of small round cells, shows a more general cellular infiltration, particularly in the papillary and sub-papillary portions of the derma. Numerous capillaries were found filled with blood-corpuscles and surrounded by dense masses of small cells, some of which presented elongated forms, as if in process of conversion into connective tissue.

Transverse sections of some of the smaller vessels showed their walls to be thickened by a homogeneous mass, in which here and there a few nuclei and some granular matter were seen.

A longitudinal section of a hair-follicle, with its inclosed hair, was encountered near the centre of the section, the bulb of which was encompassed by a dense cellular mass (Fig. 2). The follicle was unchanged except at a point directly above the bulb, where the epithelial cells of both the outer and inner root-sheaths were separated, disintegrated in places and infiltrated by small round cells. Extending from this place to the outlet of the hair through the epidermis the outline of the follicle is well preserved, though surrounded by the general infiltration throughout the derma. Situated to the right of the follicle (Fig. 2) the cellular infiltration is denser and the vascular changes the most pronounced.

Many disintegrated cells and much granular matter were found scattered throughout the section in this locality.

The papillæ are here crowded with small cells which have penetrated between the intercellular spaces of the rete, obliterating the boundary line between it and the cutis.

The lowermost rete cells have lost their normal contour and appear ragged and granular, while almost midway in the epidermis a separation of the superficial and deep cells has taken place, causing the elevation and change in the epidermis noted before its excision.

The space between these separated strata is occupied with granular matter and cell detritus. Above, the cells have more or less lost their stratified character; they appear granular, their outlines are indistinct, and as a rule their nuclei can no longer be distinguished.

With hæmatoxylin the affected portion of the epidermis stains a much lighter hue than the adjacent healthy part, though little difference in this respect was noted with borax-carmine. Many of the rete cells at the periphery of the detached portion show a brightly-stained nucleus centrally or peripherally situated, while the cell protoplasm is unstained.

The dermal and epidermal changes here described correspond to the situation of the papule in the excised piece of skin, and seem to show beyond all doubt that the essential histological changes in acne varioliformis take place outside of the hair-follicle, contrary to the view which has heretofore been generally maintained.

Examination of a Papule after the Formation of the Central Necrotic Mass.—The situation, shape, and relation of this broken-down tissue to its surroundings are well shown in the drawing (Fig. 3). In the section the central slough extended deeper into the cutis, and the papule was not so elevated above the *niveau*.

Examined under a low power the mass appears finely granular, its central part staining a lighter color and appearing more homogeneous than the periphery.

With a higher power the granular matter is found to consist of cell detritus, small round cells undergoing fatty degeneration, with the remains of the reticular structure of the cutis and of the epidermis.

Boeck examined the necrotic portion of the skin in his case of acne frontalis s. necrotica, and found it possible to demonstrate the elastic tissue of the skin quite unchanged by the pathological process. I was unable to do this by the staining method used by him, Ziehl's solution of fuchsin followed by a watery solution of picric acid. The fuchsin solution stained the mass a deep uniform red, while the portion corresponding to the stratum corneum was colored yellow. With borax-methylin-blue solution the nuclei of a few of the remaining rete cells were colored, together with a number of the small cells.

The concentric ringed structure of necrotic mass which Boeck speaks of as present in the case examined by him was not noted, perhaps because the degenerative changes were too far advanced in the case under consideration. The necrotic mass was rendered exceedingly brittle by the reagents used, so that it was difficult to preserve the sections of it complete. The derma beneath and on either side was infiltrated with small round cells, especially about the vessels, while at the line of demarcation a considerable amount of granular detritus and a number of red blood-corpuscles were present.

The stratum corneum above on either side was thickened and separated, and the stratum granulosum absent. A few minute cysts, caused by the breaking down of rete cells, were seen, and a number of these cells were undergoing vacuolation. The epidermis further removed from the conical mass was unchanged.

A large number of sections from each of the papules excised were stained for micro-organisms by Gram's method, Kühne's method, and by Ziehl's solution of fuchsin, without result except in the papule last described. In this a few long slender bacilli stained a deep blue were seen in the tissue of the derma adjacent to the separating mass. In the granular débris surrounding the abscess cavity small cocci in groups were discovered, but nothing which give any clue to the nature of the disease.

Especial attention was directed to the subcutaneous nodules in the first specimen described, but no organisms of any kind could be found in them.

Résumé.—The result of the microscopic examination in this case of acne varioliformis would seem to show that the lesion begins as a deep-seated small cell infiltration about the coil glands, which are situated beneath the hair-follicles. In the beginning several independent foci of inflammation are present, which subsequently coalesce, producing a generalized infiltration of the derma with a tendency to central degeneration. As the infiltration approaches the surface it penetrates and disintegrates the overlying epidermis, separating it from the adjacent tissue.

The central dry necrotic mass which represents the final stage in the evolution of the pathological process is made up of the epidermis with the underlying tissues of the derma, which have undergone a peculiar degeneration and have become separated from the adjoining tissue by a sharp line of demarcation. The examination, unfortunately, gives little insight into the nature or cause of this singular affection, nor reveals why the affected tissues should be thrown off *en masse* rather than undergo a liquefactive degeneration.

One would be led to suppose, however, that some agent, bacterial

or chemical, had played an active part in the inflammation, causing a reaction on the part of the tissue and an endeavor to throw off the offending cause and its results. The formation of pus, which is not a constant feature of the papules, was doubtless due to a secondary infection by pus cocci.

Pathological Literature.—As far as I have been able to ascertain, the foregoing examination is the only one that has been made of a beginning papule in this affection.

Dr. Grunewald (*Monatsheft für prak. Dermatologie*, Band IV., No. 3, 1885) reports a case of universal acne varioliformis, terminating in death, in which a microscopic examination was made of a number of the excised lesions. The histological changes in this case are, however, so entirely different from those in Dr. Bronson's case that they must be looked upon as distinct affections.

In Dr. Grunewald's case they were confined almost exclusively to the epidermis and the papillæ, the floor of the cicatrix being formed of one or two of the lowermost layers of rete cells.

Boeck, in his case of acne frontalis s. necrotica already referred to (*Archiv für Dermatologie und Syphilis*, Heft 1, 1889), examined only the separated necrotic tissue.

Of this he gives a minute and careful description, and concludes that the inflammation begins in and about the hair-follicle, rapidly extending, however, to the surrounding tissues and involving them in the destructive process. He mentions finding masses of small streptococci deep in the hair-follicle, and also small round fungus spores of double contours, which could not be stained, but were rendered more distinct by means of caustic potash.

Pick, under the title acne frontalis seu varioliformis (Hebra), acne frontalis necrotica (Boeck) (*Archiv f. Dermatologie und Syphilis*, p. 551, 1889), briefly narrates the result of the microscopic examination of the first-mentioned disease, which he regards as a distinct affection from the latter. His examination of the final stage of the process failed to reveal a connection between it and the hair-follicle or sebaceous gland.

Leloir and Vidal (*Traité descriptif des Maladies de la Peau, Symptomatologie et anatomie pathologique*, p. 23) examined two advanced papules from the forehead from a case of acne varioliformis. They found the remains of the orifice of a hair-follicle in the degenerated tissue, and in the derma a small-cell infiltration which had preserved in part the outline of the degenerated follicle. They conclude that the affection is a perifolliculitis, terminating in destruction of the hair-follicle and its sebaceous gland.

REPORT OF A CASE OF LUPUS VULGARIS TREATED WITH KOCH'S TUBERCULIN.

By HENRY P. LOOMIS, M.D.,
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AND
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THE case which is here presented offers the following points of interest:

First. It represents the late stage of a disease of long standing, the advance of which, all other methods employed had failed to check or retard.

Second. It was complicated by an epitheliomatous growth which allowed comparison to be made of the relative value of lymph in the two conditions.

Third. At the present time the patient is apparently cured, as far as can be determined by local appearances and non-reaction to large injections.

Fourth. The series of photographs taken by Dr. Robert M. Fuller give an ocular demonstration of the physical changes which occurred during the progress of treatment.

The patient, a woman 65 years of age, was admitted to Bellevue Hospital on the 18th of December. She has been under treatment for twelve weeks and has received in all twenty-two injections, the largest being 0.015 c.c. Immediately upon entrance to the hospital, she was put to bed and kept there until injections failed to produce any reaction —a period of four weeks. The temperature, pulse, and respiration were taken every two hours, night and day, during the first month, every four hours during the second month, and lately but three times a day. Every change in condition, both local and constitutional, was recorded daily. Thanks are here due to the house staff of the hospital, Drs. Pope, Towlerton, and Knight, for the painstaking care which the case received. The most marked local changes and almost all the constitutional reactions occurred during the first fourteen days of treatment. After this period the injections produced fever reactions but twice, although slight local disturbances were noted during the entire first month.

Five weeks after the commencement of the treatment, the case appeared to be cured, and since this time it has been carefully watched for a return of the symptoms, and although repeated injections, even as high as 0.015 c.c., have been given, no local or constitutional reactions have been produced. The injections appear to cause local disturbances in the epithelioma, but no curative process has occurred in

this to warrant the hope that it has or will be permanently benefited by the treatment.

History of the Case.—No definite family history could be obtained from the patient, except that both parents had lived to be nearly 70 years of age; she had five brothers still alive and one sister who died of a fever. There was no consumption or skin disease in the family as far as she knew. She was perfectly well until sixteen years ago, when her present trouble began, as a small nodule on the inner side of the nose; it then extended to the external surface and spread downward to the upper lip, and finally involved the cheeks. The patient said that when the disease began to involve the skin of the face, it would always start in the form of small lumps, situated beneath the skin, which would increase in size for a time, become soft, then ulcerate, the result being loss of more or less tissue. By this process, the soft parts of the lower portion of the nose became entirely destroyed eight years ago. The disease has advanced very slowly during the last five years, but in spite of a number of operations, which consisted, as far as could be learned, in scraping, cauterizing, and applying various substances to the ulcerations, the disease had not been checked.

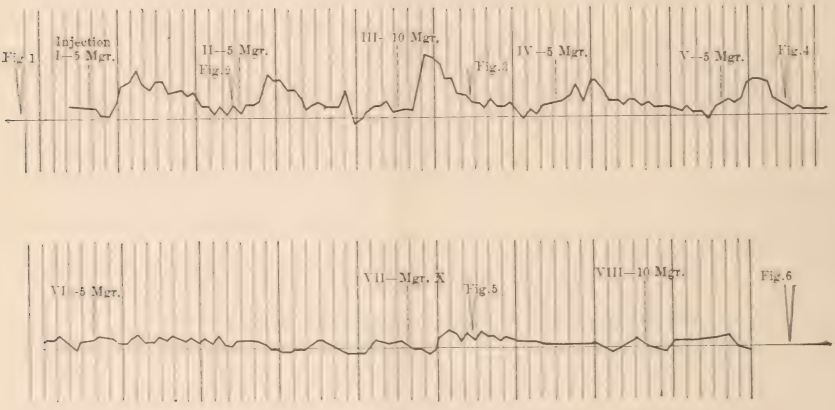
Local Effects of the Injections.—When the patient first came under observation, the disease seemed to be quiescent and the appearance of the face was as follows (see Fig. 1): The lower portion of the nose, including both cartilages, had been entirely destroyed and cicatrized. The right side of the cheek was slightly swollen, hard to the touch, and numerous disseminated lupus nodules of various sizes were felt beneath the skin, which here and there presented red patches covered with small scales. On each side of the nose was a small superficial ulcer of a yellowish color. The left side of the face was red, glazed, slightly swollen, and presented the appearance of cicatricial tissue. Just above the left angle of the mouth, was a cauliflower growth one and an eighth inches in diameter, presenting all the physical characteristics of an epithelioma.

The patient received the first injection of 0.005 c.c. on December 19th, at 3:30 P.M. No effects were noted until 9 in the evening, when the patient complained of pain and smarting in the face and severe pain in the epigastrium. At this time, a slight serous discharge appeared on the lupous surfaces of the right cheek. During the night the redness increased, covering the whole face, and pus began to exude from the epithelial growth. At the same time the temperature rose and reached the maximum—103°—fourteen hours after the injection. The day following the first injection the temperature slowly

decreased, but still remained above 101°. The whole face, with the exception of the forehead and chin, was hot and of a bright red color —in places almost purple: the lupus nodules beneath the surface of the skin were swollen and painful; from their surface and from the cicatricial tissue of the left cheek drops of thick serum exuded (see Fig. 2).

On December 21st, the patient's temperature having reached normal, a second injection of 0.005 c.c. was given; this was followed by a fever of reaction, which reached its maximum—102½°—nine hours later. With the exception of an increased redness of the face, no local effects from this injection were observed. The following day, December 22d, as the temperature remained above normal, no injection was given.

December 23d, four days after treatment was commenced, an



injection of 0.01 c.c. was given at 1 P.M.; this was followed by a chill six hours later, and at 9 P.M. the temperature had reached 104⅕°. During the night the patient was very restless and at times delirious —attempting frequently to get out of bed. She complained of great pain in her face, severe headache, and an oppression in the chest. During the fever of reaction the face was hot, angry-looking, of a purplish-red color, and covered with thick exudations resembling apple-juice. The epithelial growth was soft, and on pressure yielded a large amount of pus: the tissues around it were intensely inflamed.

Fig. 3, taken after this injection, cannot represent the intense crimson color of the face which existed over the right side of the nose, especially about the seat of the ulcer and over the right cheek.

Hidden tubercles in the apparently healthy tissue of the cicatrized

left cheek now became apparent, and were covered with a thick exudation.

Words fail to describe the intense local disturbance produced by this 0.01 c.c. injection.

A day elapsed before another injection was given. This consisted of 0.005 c.c., and was followed by a moderate fever of reaction which did not go above 101½°.

On December 26th, the seventh day after the initial injection, the redness and tumefaction of the inflamed area began to subside and crusts to form. These first appeared as large thick scales on the right side of the nose, beneath which was a collection of pus. There was a secretion of purulent fluid from the right eye. A small, thick crust formed over the ulcer on the left side of the nose.

On the following day, December 27th, the fifth injection of 0.005 c.c. was given, followed only by a moderate reaction.

Fig. 4 was taken on December 28th, when the face presented the following appearance: The redness, tension, and tumefaction had markedly diminished, large crusts had formed over the inflamed area, and numerous scales were dropping off. The tumor at the angle of the mouth was dark, puffy in appearance, and discharged pus at intervals; the hyperæmic zone around it had disappeared and its base was indurated. The patient said she experienced no discomfort and felt better than at any time since treatment began. An injection on December 29th, produced scarcely any local or constitutional reaction.

On January 2d the seventh injection of 0.01 c.c. was given, after which the patient complained of pain in the head and chest. The temperature reached its maximum of 100° at 3 A.M.

Fig. 5, taken the following day, faithfully represents the patient's appearance. The improvement was decided, the redness was much less marked and there was no discharge. Many of the crusts were dried and semi-detached or fallen off, and the exposed skin looked less indurated and inflamed. The tension of the skin had entirely disappeared, and the large crusts on either side of the nose were still adherent. On the left cheek was a large area of new, healthy skin. The tumor at the angle of the mouth was less pronounced and its area was diminished. It still contained pus and presented no marked improvement over its first condition.

Nine days elapsed between the time of taking Fig. 5 and Fig. 6, during which period the patient had received two injections of 0.01 c.c. each, followed by no local or constitutional reaction. The temperature after each injection became for a time subnormal. Fig. 6 shows the appearance of the face when nearly healed; there is no redness; the crusts have fallen off and exposed a new, soft, and apparently

healthy skin; the surface of the left cheek is smooth and white; the ulcers on either side of the nose have healed without leaving a scar. The tumor is dark in color, nodular, presenting a lobulated appearance, and, on pressure, is painful and exudes a drop or two of pus.

From January 12th to March 1st, the patient received in all, six injections of 0.01 c.c. each, none of which caused any reaction. The last injection of 0.015 c c. was given on February 28th. This being followed by no reaction, treatment was suspended, and at the time of writing (March 14th) the patient's face presents a healthy appearance, with the exception of the nasal deformity and the epithelial growth. The skin is soft, smooth, slightly paler than usual, and no nodules can be felt beneath the surface: it is difficult to locate the site of the former lesions; the tumor presents the same appearance as when treatment was commenced.

Remarks on the Case.—The local reactions seen in this case were typical and present the various stages as described by Professor Koch. They were by no means so severe as some seen in the private hospital of Professor Von Bergmann in Berlin, where the exudations were hemorrhagic in character and the constitutional disturbances so great that free stimulation had to be resorted to, to sustain the patient.

Sufficient time has not yet elapsed, since treatment was stopped, to say whether the lupus development in the face will return or not.

It must be remembered that after the face was healed, injections of 0.01 c.c. were given on an average twice a week, which may have had the effect of temporarily preventing the return of the disease. In answer to the question, Is the disease at the present time entirely destroyed or only apparently so? all that can be said is, that the patient has been examined by a number of physicians, including Drs. Morrow and Piffard, the former of whom says he can recognize no lupus nodules about the face.

While under treatment the patient has gained three and a half pounds in weight. Her physical condition is much improved, and she looks fully ten years younger than when she came into the hospital.

The only medicine given was cod-liver oil after meals. Similar changes were noted after the injections in the epithelial growth to those seen in another case of epithelioma of the face which was under treatment at the same time. Local changes were produced in the tumor, but not of a reparative character. When treatment was completed, no material change had taken place in the growth.

As far as our observations go, we have never seen any favorable change in epithelioma follow injections of the lymph.

An interesting feature was the power of the lymph to render apparent, tubercular nodules in places where they were unrecognizable

before treatment began. This was seen in the apparently healthy cicatricial tissue of the left cheek. After the 0.01 c.c. injection of December 23d, tubercular nodules appeared on the left cheek, and were soon covered with a thick apple-juice exudation.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

205TH REGULAR MEETING.

DR. E. B. BRONSON, *President, in the Chair.*

A Case of the Erythematous Type of Dermatitis Herpetiformis.—Presented by DR. G. T. ELLIOT. Male, aged 45; was first seen in September, 1890. Three years ago malarial fever, five years ago gonorrhœa. He states that two years before the eruption began he had severe family and business worries and troubles, which led to periods of nervous excitement, sudden and unaccountable feelings of fear at night, and also great depression. When the eruption began, two years ago, it showed itself on the inside of the right upper arm and then on left arm, afterward on the back and chest, and more lately on the legs.

The first lesions are said to have been pustules, but these have been replaced by the erythematous patches present at the time of the first visit. These were of all shapes and sizes, round, oval, or irregular, and as large as silver dollars or nearly the whole hand. They were dusky red in color and slightly elevated, much resembling urticarial lesions. The cutis where they are situated is thickened slightly, but not indurated. Those that have faded have left a slight yellowish pigmentation behind. In addition to these there were here and there on the surface groups of papules. The patient complained of the most intense pruritus. He said that he had not been free from the eruption or itching since the beginning of the disease. While under observation it was seen that one of the erythematous lesions began as a small patch and gradually increased in size, no involution, however, of any portion taking place, and it was also noted that some of the patches began dark purplish in color or purpuric in character. The lesions were very persistent, some of the patches having remained unchanged for months. He was given ichthyol to use locally and obtained great relief from the itching, as well as disappearance of many of the patches. The patient came back a week ago, after an absence of three months, with a relapse, the lesions present being substantially the same as previously, only of a very light red or yellowish color. The pruritus from which he had been free had returned and was again very severe.

DR. LUSTGARTEN did not think the new name added anything to our knowledge of the condition of this case, which he considered as a form of urticaria perstans.

DR. ALLEN regarded the lesions as urticarial wheals, and as portions of the skin were pigmented he thought it a case of chronic urticaria.

DR. FOX hoped that a name would be found that would be comprehensive enough to define this class of cases. Urticaria perstans seemed to him an

absurdity, as the essential feature of urticaria was the rapid disappearance of the lesions. The case presented recalled a similar one shown to the society several years ago, in which lesions like those in this case covered the patient's body in groups and recurred every week or two. The patient's tongue looked like raw beef, and small vesicles occasionally developed upon its mucous membrane and sometimes upon the skin, but for the most part the eruption was similar to this and was not vesicular in character.

DR. BRONSON asked if itching had been a marked symptom.

DR. ELLIOT replied that the itching had been the most distressing symptom of the disease. This latter had, moreover, presented the cardinal symptoms of Duhring's dermatitis herpetiformis. Great chronicity and succession of relapses, multiformity of the cutaneous symptoms—grouped papules as well as erythematous patches—excessive pruritus, pigmentation, and rebelliousness to treatment. These characteristics had led him to make the diagnosis of dermatitis herpetiformis erythematosa, and to regard the disease as belonging in that group of diseases.

He did not think it was possible to consider the eruption as an example of chronic urticaria. The lesions were in no particular such as are met with in that disease. Some of the patches remained in the same condition for several weeks without change, and though resembling urticaria slightly, were yet too sharply defined—offered too many evidences of inflammatory infiltration—to be included in that form of disease. Furthermore, under the microscope marked inflammatory changes were observed, and such were not found in urticaria.

Lupus of the Nose.—Presented by DR. ALLEN. This case had been treated by pyrogallol, to compare the result with that in other cases of lupus in which treatment had been begun at the same time with Koch's lymph. Though no case had recovered under the tuberculin in his experience, this case had almost, if not quite, done so. For the past two weeks it had appeared almost well, and leaving off the pyrogallol and mercurial plaster, he had made local applications of Koch's lymph after causing the surface to bleed slightly by brisk friction with green soap. No reaction followed.

DR. FOX was inclined to believe that vigorous local treatment would accomplish more in less time than injections of Koch's lymph, but it was possible that the lymph would cure the disease with more comfort to the patient.

DR. MORROW said that while the improvement in Dr. Allen's case was satisfactory, it could by no means be considered cured; there was still positive evidence of existing disease.

DR. FOX had had the opportunity of treating a number of cases of lupus with the lymph at the New York Skin and Cancer Hospital. In one of the cases so treated there was absolutely no sign of the disease remaining; in another, very decided improvement had taken place. In both of these cases, however, the disease was almost cured when the lymph injections were instituted, so that they can scarcely be taken as brilliant examples of cures by the lymph.

DR. BRONSON referred to a case of lupus of the nose that had been injected with Koch's lymph for nearly two months. No general reaction took place until a dose of three or four milligrammes had been given, and then the febrile reaction was slight; the local reaction was at times quite marked, and was followed for a time by a decided improvement. The ulceration and lupus nodules had almost entirely disappeared. After the improvement

reached a certain stage, however, the injections seemed to have no further influence on the disease, and ulceration recommenced, notwithstanding a continuance of the injections, and at present the case appears to be as bad as at first.

DR. ALLEN believed that the injection treatment of lupus would have to be supplemented by surgical procedures. He referred to a case treated by himself, in which, although a dose of fifteen milligrammes had been reached and temperature reactions continued, the disease was in apparently the same condition as when the patient entered the hospital, over two months ago, though some improvement was noticeable on careful examination.

A Case of Leprosy Treated by Koch's Lymph.—Presented by DR. ALLEN. The patient had been in the hospital for a number of years and had greatly improved under chaulmoogra oil. A new eruption of macular and tubercular lesions had appeared shortly before inoculations were begun. Little reaction had followed the first dose of one milligramme. After four milligrammes on February 21st the temperature reached 103.4° and a peculiarly bright red erythematous or urticarial eruption appeared, some of the previously present leprous lesions became puffy, elevated, and tender, and either brighter red or bluish in color. Other lepra lesions remained unchanged.

DR. FOX had injected a case of leprosy with the lymph without result. He had observed in two cases of leprosy a condition similar to the subcutaneous nodules which Dr. Allen's case presented.

In his cases the eruption was acute and painful, resembling erythema nodosum, and came on after the tubercles and patches of the original disease had in great measure disappeared.

DR. MORROW said that it was very important to differentiate between the changes due to the natural evolution of the disease and the effect of the treatment. He believed that this patient had shown manifestations of a recurrence of the disease before the treatment was used. The case presented altogether a different appearance from what it did when he examined it, three months ago; there were then no tubercles upon the buttocks or sides. He was disposed to think that these lesions might be due to the natural development of the disease. He thought we should give due credence to other observers that marked effects had followed the injections of the lymph in the tubercular form of leprosy.

He had used the lymph in one case of leprosy in which he had given as high as twenty milligrammes without reaction. The only effect noticed was an increase of the pruritus, which was formerly an annoying symptom, but which had been quiescent for several months before the injections were begun.

DR. PIFFARD said that the case presented to-night had been sent into Charity Hospital by him ten years ago. At that time the patient was extremely emaciated, and so feeble that it was necessary to carry him from the boat to the hospital. He was treated with hoang-nan—the fad at that time—and in two months he was able to serve as a boatman on the ferry. Since then he has been treated with hoang-nan, or its equivalent, strychnine, and chaulmoogra oil. His general condition is now excellent. He was born in Bermuda, a place where leprosy is not prevalent. The disease first made its appearance in Baltimore, Md.

Lupus of the Nose and Upper Lip.—Presented by DR. ALLEN. Patient was a Pole who spoke neither English nor German, and no history had been obtained. The nose was diffusely red and infiltrated. The tip was atrophic

and pointed. There had been loss of tissue from the right ala. The upper lip was likewise infiltrated and covered with an adherent dirty-gray crust. Dr. Allen said it was undoubtedly a case of lupus from the appearances presented, though he had seen the patient for the first time that afternoon and could get no definite statement regarding it.

Tuberculosis Verrucosa Cutis.—Presented by DR. FORDYCE, with the following history: The patient, a German, aged 25 years, was first seen six months ago. At that time he had a brown-red elevated patch, irregularly oval in outline, about three centimetres in its long diameter, situated upon the dorsum of the left hand. The patch was quite firm in consistence, its surface slightly verrucose, and here and there depressions in the horny layer of the skin were visible.

The affection followed a cut made on the hand with a scythe two and a half years ago. It began as a brown-red tubercle, and has since then been extending at the periphery and in thickness. There has been no discharge from it at any time, and no pain has attended its development.

No tendency to central involution of the patch has been manifest, and no characteristic lupus tubercles were present. A small excised piece of the growth was found, on microscopic examination, to show marked thickening of the rete layer, its interpapillary portions being broadened and bifurcated in places; in other parts of the section long processes of rete cells extended deeply into the derma.

The corium was the seat of a dense small-cell infiltration, among which a few giant cells could be distinguished. A few sections were stained by Ziehl's method for tubercle bacilli, but none were found.

The patient presented himself again after six months with a slight extension of the infiltration, which otherwise had remained unchanged.

DR. FOX was impressed by the close resemblance of this case to one which had been under his observation in hospital. In the case seen by him the growth was in exactly the same location, but somewhat smaller. It had been treated by injections of Koch's lymph, and during the first few weeks seemed to improve, but since that time the treatment has been without result. He regarded it as a case of lupus verrucosus, or tuberculosis verrucosa cutis.

DR. KLOTZ desired to know if Dr. Fox would identify lupus verrucosus with tuberculosis verrucosa cutis. He always understood the latter form of cutaneous tuberculosis to be a distinct variety.

DR. LUSTGARTEN said that the case presented was identical with the original cases described as tuberculosis verrucosa cutis.

Case for Diagnosis.—Presented by DR. BRONSON. The patient was a little girl, 4 years of age, who since early infancy had suffered from pruritus, with various lesions of the skin on the legs and arms, more particularly the outer aspects. The flexor surfaces had always been smooth and free. There was at present a condition of roughness and dryness of the skin in these situations, with here and there some signs of eczema. The roughness was chiefly due to papillary elevations at the sites of hair-follicles.

DR. ELLIOT regarded the case as an ichthyosis upon which an eczema had developed as a complication. He had seen a number of such cases in children, who would retain their distinctive ichthyotic symptoms after the eczematous ones had been removed by treatment.

DR. TAYLOR thought the case one of chronic squamous eczema, as the history indicated such an affection rather than an ichthyosis.

DR. KLOTZ thought the disease a mild ichthyosis, similar to a case that he had treated with pilocarpine injections. In his own case intense itching was present, together with an eczema. The condition of the patient was permanently improved by the injections.

DR. MORROW thought the condition distinctly an ichthyosis, and the eczema merely a superadded condition, having no relationship whatever to the malformation of the skin.

DR. PIFFARD had treated ichthyosis with pilocarpine years ago at the Charity Hospital.

DR. BRONSON said the query arose in his mind, What was the relationship of this and similar cases to prurigo?

The case was evidently neuropathic, as the pruritus was entirely in excess of trophic changes in the skin. The disease occupied the same parts of the body as are affected in prurigo, and was attended with decided motor disturbance, which was characteristic of the prurigo of Hebra. In this case the papules, which could be felt, were plainly associated with the hair-follicles, and also, he believed, with spastic contractions of the arrectores pilorum muscles. There was, in all probability, very decided hypertrophy of these muscles. He thought it would be a matter of interest to collect those cases which were allied in their pathogenesis to prurigo, and when all such were collated, he believed that the importance of the prurigo of Hebra as an independent form of disease would be much diminished.

Lupus Erythematosus.—Presented by DR. BRONSON on account of the peculiar violaceous color of the eruption. The disease affected the face of a man 93 years of age. He was cachectic and had been a heavy drinker. The patches occupied the face and neck. The nose was almost entirely covered. There were large patches on the cheeks and some of a curvilinear shape on the neck. The color at first had been a dusky red and in places purplish. They were associated with considerable cicatrization.

DR. KLOTZ thought the scar behind the ear resembled that from lupus vulgaris. At the same time, the symmetrical distribution of the various patches would be very extraordinary in that variety of lupus.

Some years ago he treated a case which presented features of both diseases. In outline the eruption was a perfect butterfly, leaving only a small piece of the nose unaffected; the borders of the patch showed distinct lupus nodules.

DR. PIFFARD believed the case to be lupus erythematosus, and while he recognized the clinical difference between the two varieties of lupus, yet he believed them to be closely related.

DR. BRONSON said that when the case first presented itself to him the patches were decidedly raised, of a deep violaceous hue, and very soft. Moreover, there was a marked pigmentation, which gave the affection a more dusky coloration, which remained on deep pressure. The margins of the patches were also distinctly elevated and sharply defined; marked hemorrhage followed scarification. The patient was in a condition of decided cachexia, his skin being of a yellowish color, which made the disease stand out more distinctly. He had not seen anything in the eruption which suggested lupus vulgaris, and furthermore, the fact that the disease was only two years old was a sufficiently strong argument against the diagnosis of lupus vulgaris.

DR. FOX stated that, contrary to Dr. Piffard's belief, he had long taught

that lupus erythematosus and lupus vulgaris were distinct affections, but since the lymph treatment had come into use he had been surprised to see that in a number of cases of lupus erythematosus injected with lymph a decided local and general reaction had taken place. His experience had been contrary to that of Professor Pick, who had not seen a reaction from the lymph in lupus erythematosus.

Keratoma.—DR. PIFFARD stated that long descriptions of pathological conditions were often found in French and German journals that contained unessential matter. He believed it better to write short papers more frequently, specifying what is seen in the fewest possible words, and therefore

presented the following paper, believing that his description of the microscopic appearances contained all that was essential :

A short time since I removed a small tubercle from the back of the hand of a gentleman who at the same time was suffering from an extensive lupus involving the infra-auricular region of the neck. The little tumor was hard, and to the sight and touch closely counterfeited an epithelioma, for which I mistook it. On microscopical examination, however, it proved to be a keratoma, and exhibited the appearances shown in the accompanying illustration (see cut). These may be briefly described as follows : The growth consisted, first, of a sharply-circumscribed hyperplasia of the stratum corneum, the cells of which are nucleated. These nuclei are rod-shaped, their long axes being parallel to the surface of the skin. The superficial ends of the sweat-ducts are noticeably enlarged and more distinct than in the adjoining normal

portions of the skin (not shown in the illustration). The stratum Malpighii is decidedly thinned. In the pars papillaris we find a dense small round cell infiltration several times thicker than the rete and slightly separated from it.

It will be seen, then, that in this particular instance the lesion consists essentially of hyperplasia of the stratum corneum, atrophy of the stratum Malpighii, with superficial small-cell infiltration of the cutis vera. In other words, the rete lies between the upper and the nether millstone, and suffers in consequence from the downward pressure of the one and the upward pressure of the other.

If the horny new growth be examined with a Nicol prism it will be found to polarize* strongly, as shown in the accompanying photo-micrograph (not reproduced).

We find nothing, thus far, on microscopical examination that gives the slightest clue to the etiology of the affection.

It will be noticed, however, that the minute appearances here shown differ widely from those observed in another form of keratoma, namely, the common corn (clavus), in which the central plug is inserted, as it were, in part in the derma, instead of the new growth resting upon the derma, as in the present instance.

DR. MORROW presented photographs of **Multiple Pigmented Sarcoma of the Skin** on behalf of Dr. B. E. Vaughan, who furnishes the following notes of the case:

Louis Francesca, aged 54, Italian; has lived twelve years in America; has wife and five healthy children. His first trouble began about six years ago, when small black spots began to appear on hands, accompanied with a

* I have found that certain color reagents will destroy polarization even in normal epidermis.

great deal of itching. Soon similar spots appeared on feet. For three years past he has been unable to work. Eighteen months ago, when I first saw him, the feet and hands were much enlarged, but no marked ulceration present, and he could work about the house, but suffered quite a good deal from pain. At those times he had no fever or any disturbance of general health. I saw him again the past summer, and a great change had taken place. Large ulcerating areas on both feet and pain very marked. At times his temperature was 100° to 103°. Appetite good and no evidence of visceral involvement. Examination shows black, irregular, elevated spots over arms, hands, and legs, extending upward as far as waist posteriorly. Hands enlarged; nodules present which have tendency to ulcerate. Other nodules seen on chin, eyelid, and ear. The feet are markedly enlarged, the seat of warty, cauliflower-like growths ulcerating with a very fetid, disagreeable odor.

The points of interest are the comparative rarity of the disease, the length of time it has lasted without involvement of the viscera, and the extent of the lesions without producing death.

Correspondence.

WILSON ON THE NATURE OF "MOLLUSCUM BODIES."

EDITOR JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

Sir:—I do not know whether any one has as yet thought of calling attention to the following, which I copy from "Wilson on Diseases of the Skin," fifth London edition (1862), and which is of peculiar interest to-day, when so much of it attaches to the true nature of the "molluscum bodies":

"I disagree with Dr. Paterson in considering these cells as *peculiar organisms, capable of nucleolar propagation when transferred to an appropriate nidus in another individual*, and simply regard them as the normal sebaceous cell which contains a granular substance, filling it more or less completely" (p. 574). The italics are mine.

On the next page he alludes to Dr. Paterson's description of a granular nucleolar mass (which he regarded as "an internal vesicle") separated by a considerable clear interval from the cell membrane. This tallies closely with modern descriptions of the psorosperm, and from the foregoing quotation it would seem that we have here a remarkable instance of scientific insight exercised years before the actual proof of the theory then first propounded.

Very respectfully yours,

ST. LOUIS. JOSEPH GRINDON.

Selections.

RESULTS OF THE KOCH METHOD IN LUPUS.

Results in Lupus Erythematosus.—Lewin presented a patient at the Berlin Dermatological Society as one of lupus erythematosus, in which an effect had been produced by the Koch injections. Thibièrge, who saw the case, looked upon it as an example of lupus vulgaris of the non-ulcerating variety, and Köbner is said to have held the same view. In a case of Dr. Schweninger no reaction occurred.

Cornil, on the other hand, reports two cases in which febrile reaction was most characteristic, but only in one of them was a local effect at all manifest.

Arning reported two cases of lupus erythematosus treated by the new method at the meeting of the Hamburg Medical Society, December 2d, 1890. They both showed marked reaction as regards fever, etc., but no especial change in the lupus patches. In one of the cases, after a two-milligramme dose, there was general restlessness, increased heart action, without much increase in temperature, and an unusually severe erythema. Here the lupus areas took part in the general reddening of the surface without showing any specific reaction peculiar to themselves.

Kaposi has observed, in a womon with acute lupus erythematosus, a disease which he maintains is positively not of tuberculous origin, most active febrile, as well as local reaction. A case of my own at Charity Hospital, now receiving eight milligrammes, has shown after each inoculation both local and general reaction, and has shown some improvement.

Kochine Exanthemata.—The eruptions which have so far been observed, as a result of the lymph treatment, are mostly erythematous. Scarlatiniform, morbilliform, urticaria-like, bullous, and herpetic eruptions have been reported, besides, in several cases, icterus of more or less pronounced type.

In Arning's case the eruptions began upon the flexor surface of both elbow-joints, and then were seen to develop upon the front and sides of the trunk as a diffuse scarlatina-like redness, while toward the borders it appeared like a roseola with large lesions. It lasted for twelve hours and returned after each inoculation.

Sometimes the eruption is erythemato-papular, and there appears to be a tendency to polymorphism which takes away any characteristic features it might have to distinguish it from other medicinal rashes. So closely do some lymph exanthems resemble measles that they have caused observers to fall into error. In a London hospital a case was demonstrated as one of lymph exanthem until a number of other children in the ward "broke out" in the same way, and, as these had not been inoculated, it was seen that they all had measles. In some instances there is simple hyperæmia not followed by desquamation, while in others the scarlet-like redness may be succeeded by scaling off in lamellar flakes. Lindner reports a case similar to erysipelas bullosum in which ulceration followed the rupture of the bullæ; furuncular nodules have also been seen.

Results in New York have been much the same as those reported from abroad. Most cases of phthisis appear to be benefited and an occasional cure has been reported. One patient discharged from Bellevue is now exhibiting himself in a dime museum, at fifty dollars per week, as the first American instance of cure.

Just as abroad, a proportion of those in whom treatment was begun early in the history of parataloid, but probably too late in the history of their phthisis, are succumbing in spite of the inoculations. Autopsies show disseminated tuberculosis, solitary tubercles, etc. A decided reaction against the lymph is now causing as much talk in some quarters as did the "reaction" produced by the lymph some weeks ago. The public demand for immediate treatment at any price has suddenly subsided, and although there are several private institutions already in existence in this city for carrying out the

inoculations, so far as it can be learned, the number of patients received has been quite limited.

A number of lupus cases have been and are still under treatment in the various public hospitals, while a number are being discharged as improved and one as cured. Published reports are very meagre in relation to them, and the writer has endeavored to present to the readers of the JOURNAL a report of their condition so far as it could be ascertained from personal observation and the verbal statements of the observers. Through the courtesy of Dr. H. P. Loomis the cases under his care at Bellevue Hospital have been visited and examined. There are three dermatological cases still in the hospital, one having recently been discharged as improved. This patient returns occasionally for observation.

A boy of seventeen, who comes from Massachusetts, has an extensive lupus vulgaris of the face and hand, which has existed for about ten years and has caused destruction of tissue and much disfigurement. A one-milligramme injection caused a temperature of 105°. At the present time, after six weeks of treatment, ten milligrammes produce no fever and no local reaction. There has undoubtedly been great improvement, but the disease is far from being cured.

The second case seen was one of evident epithelioma of the cheek surrounded by tissue which presented the appearance of a cured or almost cured lupus. The patient was a woman sixty-odd years of age, and the disease had existed for seventeen years. The patient said it had begun upon the inner surface of the nostril and had gradually spread over the nose and face. A circular elevated tumor (probably epithelioma) on the cheek which had softened and discharged but had not been much affected otherwise by the inoculation, began, the patient said, a year ago after picking a "pimple." In this situation characteristic reactions had taken place after the inoculations, and decided improvement had been noted in all portions of the "lupus" area. No lymph had been administered since January 19th.

The patient in the next bed was a woman of about the same age, with an ulcer on the side of the nose, which she said had existed for eleven years. Patient had been under the new treatment for about the same length of time as the preceding case. On admission a red, hard, nodular mass occupied the entire right side of the nose. An irregular ulcer had resulted from a breaking down of the tissue at the margins. Under inoculation the redness had entirely disappeared, the swelling had almost wholly subsided, and the discharge from the ulcer had ceased. The diagnosis had rested between lupus and epithelioma, and, as the reactions had been marked and the improvement quite noticeable, the diagnosis of lupus was thought justifiable.

Marked improvement is reported to have taken place in a case of lupus erythematodes which had left the hospital. At St. Luke's Hospital three cases have been treated in the service of Dr. Kinnicutt. One of lupus of the ear and contiguous portions of the face and neck, of twelve years' duration, in a young woman, has received inoculations since December 11th. The parts were deeply infiltrated and of a dull red hue before treatment was begun. After the first injection an erysipelatous condition came on and there was considerable swelling of the auricle. At the margin of the patch there was a narrow zone of hyperæmia and a number of red points appeared which had not previously been noted. After reaction had subsided there was less appearance of infiltration. The whole ear was softer to the feel.

After subsequent inoculations it became much whiter and more normal in shape and color. The patch below the ear became perfectly flat and smoother than before the treatment was begun: the tendency to exudation and scaling became less and less apparent; gradual improvement has continued as the dose has been increased.

CASE II.—Lupus of the hand in a patient with tubercular infiltration of the left apex. Marked improvement followed the first inoculations, consisting in the gradual diminution of the induration and separation of the compact, hard mass into separate nodules, with healthy-appearing tissue between. Local reactions consisted simply in reddening and sensitiveness, with the development of a moderate hyperæmic areola.

CASE III.—Lupus of neck and ear in a male patient, admitted about January 1st, with evidence of unusually deep tissue infiltration and active ulcerative process. Improvement took place up to a certain point, the reaction giving the usual swelling, redness, etc. Improvement then appeared to be less marked. Patient has gained nine pounds in weight. On the 7th inst. the sixteenth injection of 0.016 gm. was given and temperature went up to 100°. There was very slight local effect, and since the third injection there has been no exudation. The subjective symptoms are improved; there is less tension and stiffness in and about the ear. An epithelioma of the hand failed to react either at the site of lesion or by fever after successive inoculations up to eight milligrammes. Dr. Kinnicutt writes: "No case in my wards is yet cured; in other words, in no case have all the areas of infiltration disappeared. On the other hand, there has been gradual improvement in all, which continues up to the present date."

In Dr. Wendt's service at St. Joseph's Asylum many children with scrofulous affections have received the parataloid and some with apparent benefit. Cutaneous manifestations of a scrofulous nature, superficial ulcerations, etc., have been healed. While in some cases the enlarged glands decrease in size, in others the glandular swellings became more pronouncedt

In the Mount Sinai Hospital, services of Drs. Jacobi and Heineman, a number of lupus cases have received treatment and been discharged improved and one cured. In an extensive infiltration of the face, which had existed for about eighteen years and had been cauterized and scraped repeatedly, the usual reactions took place. New nodules developed and again disappeared under successive injections. In a second case, which, like the first, gave a strong family history of phthisis, a redness of the penis had been noticed for five years. Three months ago this began to ulcerate, and the ulceration has destroyed part of glans and floor of urethra. General improvement and healing of the ulcer took place after the dose had reached 0.016 gm. Discharged cured.

A third case in a woman aged 33, whose mother died of phthisis, had lupus of the vulva. Gradual diminution of ulcerated surfaces until they were finally healed, and general improvement followed the treatment.

Lupus of the hand and arm, in a woman of 20, which had existed for about eighteen years, reacted as usual, became marked and scaly, and improved up to date of discharge. Local treatment is now being applied outside the hospital.

An epithelioma in a woman of 55, which involved the entire thickness of the lower eyelid and a portion of the nose, with destruction of tissue and ulceration, reacted as characteristically as the lupus cases. Improvement

has been gradual and the ulcer is cicatrizing, though a cure is not anticipated.

One case of lupus is reported from St. Mark's Hospital, in a woman of 46, involving the right side of the face since the age of fourteen. At the last report, though improvement had taken place, the affected part was still quite hard and stiff.

In the service of Dr. Shrady, at St. Francis' Hospital, an epithelioma of the lower lip showed slight general reaction after the second inoculation. In several cases of cancer experimentally inoculated at the Cancer Hospital by Dr. Shrady reaction occurred, while in others there was none. A case of lupus inoculated at the same time did not respond to the first injection.

At the Polyclinic two cases of lupus have been treated by Dr. Heineman. An Italian boy, 8 years of age, with lupus of the lower third of the nose and three small patches on the back of the thigh, has been much improved and is still under treatment.

The second case concerns a woman of 70, whose lupus vulgaris of the entire left cheek and parts of chin and right cheek has existed for forty-seven years. Excessive swelling and pain followed the first milligramme.

Though some benefit has followed the treatment, patient left the institution before any definite result could be obtained.

At the German Hospital, in the service of Dr. Kammerer, one case of lupus of the nose and lips in a young woman who had been many times operated upon surgically has been inoculated by Dr. Jacobi. Reaction took place from the first, when one miligramme was tried, up to the last, when eighty were given. The case appeared cured at one time, but after a three-weeks' interval nodules returned. The patient has lupus of the mucous membrane of the throat as well, and although the cutaneous lupus appears cured at times, reactions continue to occur, and the cicatrix, which is paling, grows red when no inoculations have been made for some time.

At the Cancer Hospital Dr. Jacobi inoculated a case supposed to be lupus of the skin surrounding the left eye and involving the palpebral conjunctiva. Little or no improvement took place, and it was decided to be a case of epithelioma without characteristic induration or waxy margin, and the patient was discharged.

In a paper read before the New York State Medical Society, Dr. Jacobi reports these and other cases. The paper will be found in the *Medical Record*.

One case of a boy with supposed tuberculosis of the posterior surface of the thigh and leg did not respond to the treatment, and the diagnosis of a non-tuberculous papilloma was made.

A patient with a papillomatous growth on the cheek was unsuccessfully inoculated so far as the tumor was concerned, but general reaction took place, and a hitherto unsuspected pulmonary phthisis was developed. The growth was excised and found to be epithelioma.

Dr. Heineman has related to me the history of a case of Addison's disease in which reaction followed the inoculations. The patient died, and at the autopsy tuberculosis of the supra-renal capsules was found.

At the Charity Hospital, in the service of the writer, one case of lupus vulgaris, one of lupus erythematosus, and one of lepra are under treatment by the courtesy of Dr. Warner, who procured the parataloid in Berlin.

Patient H., aged 15, female, has a lupus of the face and neck extending down upon the chest, which began when she was two years of age. It has never been at any time healed.

On December 27th Dr. Warner made the first injection of 0.001 gm. Temperature rose to 103.4° F. Gradual improvement has taken place. On February 13th 0.012 gm. were injected with some local and temperature reaction to only 99.8°.

Patient has opacities of the cornea in both eyes. After the early inoculations the sight became more dim and the cloudiness appeared greater. As treatment has progressed patient claims to see much better than she formerly did, and this improvement is also apparent to those who have watched her closely.

The case of lupus erythematosus which had already been much improved under scarifications was first inoculated January 4th with 0.00025 gm. This gave no reaction. Two days later 0.001 gm. produced the usual effects, both local and constitutional, in a mild degree. Subsequent injections caused severe symptoms and considerable cough. On February 13th 0.011 gm. was followed by rise of temperature to 99.8° only and some local reaction, consisting in redness and tenderness over small areas in the original patch. The improvement has been marked.

Inoculations were made in a case of lepra which had been for some time free from active skin lesions under the use of large doses of chaulmoogra oil. Recently a new tubercular and erythematous eruption had appeared. Only two inoculations have been made, with reaction only after the second.

The Diagnostic Worth of the Lymph.—It cannot be said that the value of parataloid, as an aid to diagnosis, has yet been determined, still many experimenters claim that by its use much can be learned in a diagnostic sense. Professor Pick has been led to the conclusion that the new method has a positive worth in diagnosis which he says is inestimable. In cases of rhinoscleroma in which he used it the result was negative. He also made trial of the lymph in a case of morbus Addisonii without effect from the first centigramme, but the second injection caused general reaction, and at the same time a pronounced pain was complained of in the loins, increased by pressure. Pick therefore held that a tuberculous affection of the supra-renal capsules was probable. In seven cases of syphilis the results were negative, while in thirteen of lupus all reacted.

Arning, Kaposi, Loomis, and others, including the writer, have all seen local as well as systematic reaction in erythematous lupus. Schwimmer saw general but no local reaction in two cases. The same was observed in two cases of psoriasis and three of syphilis. Kaposi got no result in two cases of syphilis even after injecting one centigramme of the fluid. A third case with an open gumma over the knee reacted promptly and showed an undoubted serous exudation at the seat of disease. In a case of sarcoma there was fever and a superficial œdema and reddening followed by diminution in size and increased mobility of the tumor.

Neumann, who had also seen reaction in a syphilitic gumma, said that in such non-tuberculous cases the reaction never showed the same intensity and regularity of phenomena as seen in lupus.

According to several observers the lymph appears to be of value in deciding the presence of lupus in cicatrices of cases supposed to be cured and in bringing to light nodules in tissue supposed to be healthy (Weber).

From the reports of reactions, both local and constitutional, in leprosy, the diagnostic importance of the Koch method cannot be said to exist as between this disease and tuberculosis, though Babes and Kalendero point

out how the differences in the reaction effects can be turned to good account in differentiating these affections in doubtful cases. Professor Maydl got marked reactions in two cases of carcinoma, and as a "control" experiment inoculated six of his chemical assistants (all supposed to be healthy individuals): three reacted in a decided manner and the other three showed no effect. Others give the same testimony. Some tuberculous cases do not react or not at all promptly, while reactions do occur in a variety of other diseases and in healthy individuals.

In this undecided condition it is gratifying that Professor Schrötter has employed parataloid for diagnosis with gratifying result. A woman of 22 was laparotomized for suspected ovarian cyst; none was found, and the case being taken for one of peritoneal tuberculosis, the abdominal wound was sewed up. Prof. Schrötter diagnosed probable carcinoma of the peritoneum. Injections of the Koch lymph up to fifteen milligrammes produced no reaction. The patient died and the autopsy showed carcinoma of the peritoneum.

Professor Drasche reported at the meeting of the Society of Physicians of Vienna, January 30th, that two cases of erysipelas showed marked reaction from a 0.002 gm. injection, while one of actinomycosis and one of gonitis did not react at all.

Peiper, as well as others, has found reaction to take place in eczema faciei.

Fortunately it is seldom necessary to rely upon the effects of the injection to decide whether or not a case is lupus, for we are left in much the same confused and uncertain state regarding the diagnostic as we still are in respect to the therapeutic value of this new discovery in phthisis.

Much evidence must be accumulated before we can put a just estimate upon the lymph as an aid to diagnosis. CHARLES W. ALLEN.

Lupus by Inoculation. J. JADASSOHN. (*Virch. Arch.*, 121, 1890.)

In consequence of an injury an ulcer developed on the finger-tip of a butcher. The ulcer resembled, though not exactly, one of tuberculous origin: shallow floor, thin, partly undermined irregular border, feeble granulations, numerous points of suppuration. Later a typical lupus patch developed on the forearm and another on the upper arm. The histological examination disclosed the tubercular nature of the lesions, though but few bacilli were found.

In a second case the lupus developed on the site of a tattoo and coincided exactly with the lines of the tattooed design. The operator, it appeared, was phthisical and had used his saliva in mixing the colors.

The author discusses the various theories of the pathogenesis of lupus and expresses his adherence to the theory of direct inoculation, in opposition to Baumgarten's theory of its hæmatogenic origin. S. POLLITZER.

Multiple Myomata of the Skin. J. JADASSOHN. (*Virch. Arch.*, 121, 1890.)

Two cases of this affection in women of 29 and 37 years respectively were observed. In the first the nodules appeared in the nineteenth year, in the second in the seventh year. In the first the affection was distinctly of a progressive character, the tumors increasing in size up to that of a hazel-nut, and also in number. In the second case the affection had become stationary, some of the tumors having latterly entirely disappeared. In both cases the tumors

occurred only on the right upper extremity ; in one they seemed to follow no preformed structures ; in the other they were associated—in the earliest stages—with the hair follicles. In the first case they gave rise spontaneously to severe pain. In form the growths were round, oval, or irregular. The diagnosis was verified by the microscopic examination. No relation to pre-existing smooth muscle fibre could be demonstrated.

S. POLLITZER.

The Relations of Colloid Milium, Colloid Degeneration of the Skin, and Hydradenoma to Each Other. L. PHILIPPSON. (*Monatshft. f. prakt. Dermat.*, XI., 1.)

The author examined histologically two cases of colloid milium occurring in the face, in one of which there were also little tumors diagnosed as hydradenoma on the thorax. The microscopic examination of these growths showed the identity of their structure with what Darier and Jacquet have described under the name of hydradenoma and Török under that of syringocystadenoma. He regards the affection described under these various names as one, and urges the retention of the name colloid milium. The essential element of the growths consists of epithelial cells grouped in roundish nests or in layers between connective-tissue bundles ; these cells undergo colloid degeneration in the middle of the clusters, and so cysts containing colloid matter are formed. The most careful study of serial sections failed to show any connection of the new growth with the sebaceous or the sweat glands or the hair follicles. In one case only could some connection with normal epithelial structure be detected—an elongated rete peg was seen to terminate in a cyst which contained colloid. The author is therefore led to the conclusion that these abnormal epithelial structures are the result of misplaced embryonal cells which had become separated from the overlying epidermis at a period antedating the development of true spiny cells ; and he defines the affection in question histologically as a benign epithelioma which undergoes colloid degeneration, and which is developed from misplaced embryonal epithelial cells.

S. POLLITZER.

On the Occurrence of Herpes Zoster during the Administration of Arsenic. L. NEILSEN. (*Monatshft. f. prakt. Dermat.*, XI., 7.)

An eruption of zona in patients who are under treatment with arsenic has been so frequently observed as to give rise to the suspicion that the administration of the drug stands in some causal relation to the eruption. The eruption has been seen during a course of arsenic in many different affections ; so Kaposi records three cases of zona during arsenic treatment of lichen ruber ; H. Hebra two ; Juliusberger two.* The eruption has been observed, furthermore, in cases of chorea, psoriasis, and other affections in which large doses of arsenic were exhibited. Authors differ as to significance of the eruption in these cases, some regarding the eruption as merely a coincidence, others as directly due to the administration of the drug. The author utilizes the records of the Communal Hospital in Copenhagen for a contribution to

*The reporter, too, has recently observed in private practice a case of zona of the right upper extremity in a patient under treatment with arsenic for L. planus. An objection to regarding the zona in these cases as a drug eruption lies in the fact that the eruption seems unaffected by the continued administration of the drug.

this question. During the past 25 years, 777 cases of psoriasis in 514 individuals were treated. Of these, 557 cases in 390 individuals were treated with some preparation of arsenic; in the other 220 cases potassium iodide was employed. Among the 557 cases treated with arsenic, an eruption of zona occurred in 10—that is, in 1.8%; whereas not one case of zona occurred in the 220 cases treated with KI. These figures become even more striking when we compare the number of zoster cases with the number of individuals treated with arsenic: we have then 10 cases of zoster in 390 individuals, or 2.6% for the arsenic cases to none in the KI cases. S. POLLITZER.

Alopecia Neurotica. S. ASKANAZY. (*Arch. f. Derm. u. Syph.*, XXII., 1890, p. 523.)

Two cases are described. A man thirty-one years old developed partial facial paralysis on the right side in consequence of the removal of a tumor of the right submaxillary region. Soon after, hyperidrosis and alopecia of the same side appeared. The scalp was unaffected. In the second case the baldness affected the face, temples, and pubes. The patient was hypochondriac and melancholic, and suffered from severe headaches and insomnia.
S. POLLITZER.

The Pathological Anatomy of Psoriasis. E. KROMAYER. (*Arch. f. Derm. u. Syph.*, XXII., 1890, p. 557.)

The author develops some peculiar theories as to the anatomy of the skin —maintaining, for instance, that the papillary layer belongs anatomically and physiologically to the epidermis, for the details of which the reader is referred to the original paper. His account of the pathological anatomy of psoriasis adds nothing to our knowledge of the subject. He rediscovers the fact already noticed by Hebra that the first changes occur in the papillary layer, and consist of a hyperæmia with some emigration of leucocytes. The process is nevertheless not an inflammation, as the cardinal features of inflammation are absent. It is rather to be regarded as a progressive disturbance of nutrition. S. POLLITZER.

The Seborrhœic Wart. S. POLLITZER. (*Brit. Jour. of Dermat.*, II., 7.)

The common senile or flat wart forms the subject of this clinical and histological study. The growths in question are shown to consist of a crust of epithelial scales, detritus, fat, and dirt, beneath which more important changes have taken place. The horny layer is thickened and the rete Malpighii markedly hypertrophied. The papillary and subpapillary layers are more or less filled with epithelioid cells, which are arranged in clusters and groups, separated by bundles of connective-tissue fibres, and which terminate abruptly in a horizontal line at the level of the subpapillary plexus of vessels. This structure probably brings these growths into the class of what Recklinghausen described as lymphangio-fibroma. There is besides a marked infiltration of fat in extremely minute particles throughout the entire growth, extending even into the intra-epithelial channels of the epidermis; as to the source of this fat, the author can find no explanation. Incidentally he details some experiments on rabbits and man which demonstrate the impermeability of the skin to fat rubbed into it from without. S. POLLITZER.

A Case of Morvan's Disease. A. JOFFROY and C. ACHARD. (*Archives de Méd. Expér.*, II., p. 540, 1890.)

The question whether Morvan's disease is a pathological entity or whether it is only a form of syringo-myelitis is not yet settled. Not much importance is to be attached to the differential point on which Morvan laid stress, that in this affection tactile sensibility is abolished simultaneously with the sensibility to heat and pain, while in syringo-myelitis the tactile sensibility is as a rule unaffected. The fact is that, as Roth and Czerny among others have shown, the tactile sensibility is neither constantly abolished in Morvan's disease nor is it always intact in syringo-myelitis. The case which the authors describe forms an important contribution to this question. A woman of 65 years had at about her thirtieth year a succession of whitlows, which attacked all her fingers excepting the right thumb and the little finger of her left hand, lasted about two months, and resulted in characteristic and persistent deformities of the fingers and nails. There is no thickening of the skin; diminution of sensibility to pain and temperature, especially on the flexor surface of the fingers, palm, and lower two-thirds of the forearm; tactile sensibility diminished; muscular atrophy very marked; no scoliosis; kyphosis in the middle dorsal region. The autopsy disclosed a cervical cord flattened antero-posteriorly, cavities with irregular contours having almost entirely taken the place of the posterior columns and horns; sclerosis of the posterior columns of the bulb; in the dorsal region round, nodular masses of neuroglia in the middle of the cord, its central canal being almost occluded by them; diffuse scleroses in the adjoining white matter; anterior roots degenerated in the regions corresponding to the destruction of the anterior horns; some peripheral interstitial neuritis of the nerves of the upper extremities; in some places atrophy of the nerve fibres, in other Wallerian degeneration. S. POLLITZER.

Ichthyosis Cornea (Hystrix) Partialis. L. PHILIPPSON. (*Monatshefte f. prakt. Dermat.*, XI., 8.)

Two cases of this affection, which has been called by others nævus verrucosus, nerve nævus, nævus linearis, etc., are described in detail and with five similar cases from the literature of the subject critically discussed. It is shown first that the generally assumed coincidence of these linear naevi with the course of cutaneous or deeper nerves depends in most cases on the imagination of the observer, and that even did such a coincidence exist, it would not help us to an understanding of the pathogeny of the affection.

Nevertheless these nævi have so constant a topography—Shearar's case, for instance, presents lesions absolutely identical in localization with those in the author's—that there must be some preformed anatomical basis for their development. Such an anatomical substratum the author finds in the lines of limitation of the areas of cutaneous nerve distribution as discovered by Voigt (*Denkschriften d. Math. Naturw. Klasse d. Kais. Akad. d. Wiss. Wien*, Bd. xxii.). Voigt has traced the lines of distribution of the cutaneous nerve ends, and mapped out the entire integument in a series of areas indicating their nerve supply. Now, the course of the nerve fibres in any region is also the direction of the line of growth, embryonal and postnatal, of that region, and the boundary lines of areas of nerve supply are therefore normals to the lines of growth. We have thus in many parts of the integument, lines which indicate the points at which the lines of growth proceedingin opposite

directions have met. We can readily understand that the collision (if we may use this term) of lines of growth may result in anomalies of structure in the lines of such collisions. A comparison of these lines, as laid down in Voigt's charts with the nævi lineares described by the author and others shows a most striking and almost perfect coincidence. The author applies the same explanation to the occurrence of other linear nævi; notably in a striking case of linear albinismus partialis in a Hindoo pictured in Hutchinson's *Arch. of Surgery*, Vol. I., 1889, Plates I. and II. So also in regard to the vascular nævi, which Virchow showed long ago occurred most commonly at points at which cavities or fissures in the embryo have been closed. These points, it happens, are also those in which, according to Voigt's charts, lines of growth meet. Altogether the author's theory is rich in suggestiveness of an explanation of the peculiar topography of many congenital cutaneous malformations. S. POLLITZER.

A Case of Purpura Due to a Streptococcus. V. HANOT and C. LUZET. (*Arch. de Méd. Exp.*, II., No. 6, 1890.)

The infectious nature of some forms of purpura is now generally accepted; indeed, Cornil and Babes distinguish three forms of purpura of bacterial origin. The following case presents some unusual features:

A woman in an advanced stage of pregnancy is attacked by a purulent cerebro-spinal meningitis. Septicæmia follows. Purpuric patches develop of the lower extremities. The fœtus is expelled and is found to have purpuric patches on the endocardium and in the liver. In these patches the presence of the streptococcus pyogenes is shown, so also in the meningeal fluid, the spleen, liver, and uterus of the mother. S. POLLITZER.

Suppuration from Drug-applications in Skin Diseases. D. v. SEHLEN. (*Centralbl. f. Bakteriol.*, VII., p. 97.)

The author induced suppuration invarious skin diseases (lupus, leprosy, trichophytina, eczema, prurigo) by the application of different drugs—ointments of chrysarobin, pyrogallol, sublimate, pyrogallol-collodium, tincture of iodine, etc. The artificial suppuration was not distinguishable clinically from the usual forms of suppuration. The pus, however, proved under the microscope to be free from pyogenic cocci, and culture media inoculated with it remained in nearly every case sterile, the few positive results being evidently the result of accidental contamination. It appears, therefore, that there may be a form of suppuration on the skin depending on chemical action and independent of pyogenic germs. S. POLLITZER.

Herxheimer's Spirals in the Epidermis. A. E. EDDOWES. (*Monatshefte f. prakt. Dermatol.*, XI., 3.)

Herxheimer found, some years ago, peculiar spiral fibres in the spaces between the cells of the rete Malpighii. These spirals were sometimes five or six times the length of the cells among which they lay, and occurred in perfectly normal skin. They were, however, most easily demonstrated in the epithelium of condylomata acuminata. They were stained dark blue by that modification of the Gram stain which Weigert has recommended especially for fibrin. Herxheimer could not satisfy himself as to their nature, though he was inclined to regard them as a part of the system of lymph channels.

Eddowes, after a thorough study of the subject, concludes that these fibres

are deposits of fibrin from the lymph, in the lymph channels between the cells. The fibrin, coagulated in more or less irregular lines in these spaces, which are necessarily much wider than the contained fibrin, contracts less than does the surrounding tissue on hardening in alcohol; their compression into the form of spirals or of zigzag lines follows as a physical necessity. The argument in favor of their fibrinous nature is the following: They stain like fibrin; a direct connection between them and fibrinous threads in the cutis may be traced; they are digested with pepsin HCl at the same rate as fibrin masses in the cutis. S. POLLITZER.

The Significance of the Figures Described as Coccidia (Psorosperms) in Epitheliomata. A. BORREL. (*Arch. de Méd. Expérimentale*, II., No. 6, Nov., 1890.)

The author has studied the peculiar structures which Malassez and Darier regard as coccidia in fifteen cases of epithelioma, and arrives at the conclusion that the so-called psorosperms, are nothing else than degenerated or otherwise modified epithelial cells. He believes that the fact that these structures occur in such different affections as psorospermosis, follicularis vegetans, Paget's disease, malignant epitheliomata, papillomata, etc., should alone suffice to raise the suspicion *a priori* that they are rather peculiarly altered epithelial cells than parasites.

All attempts at cultures of the suspected organisms have failed. The author has more or less perfectly isolated these cells by teasing fresh specimens, and attempted to cultivate them in distilled water or allowed the fragments to macerate in water. He has never found any evidence of growth or of life in these cells, examined at intervals for four weeks. From their reactions to staining fluids he arrives at the same conclusion as to their epithelial character. His specimens are fixed in Roule's fluid (saturated solution of mercuric bichloride, acetic acid 5%), the sections stained with borax-carmine and then placed for six to twelve hours in alcohol to which a few drops of a saturated aqueous solution of indigo-carmine has been added. By this method normal active epithelium is stained red; cells about to be desquamated (horny layer) or otherwise degenerated are stained blue; the peculiar structures in question are similarly stained blue. What Darier and Wickham have described as two stages in the development of the coccidia, the author looks upon as two kinds of formation which have nothing in common; on the one hand, cells with hyaline refractive walls (Pl. III., Figs. 2, 10, 14, Wickham), on the other, elements which are pseudo-cystic or sometimes intra-cellular (Pl. III., Figs. 3, 12, 13, 15, Wickham). The former he regards as cells in process of degeneration; the latter as cells undergoing some peculiar form of evolution. As to the nature of this degeneration or of the peculiar form of development, the author confesses his inability to give an explanation, but at any rate their parasitic nature is, he maintains, very far from having been demonstrated. S. POLLITZER.

The Difficulties of Diagnosis of Syphilitic Reinfection. DR. BROCQ, of Paris. (*Revista Especial de Oftalmologia, Dermatologia, Sifilografia y Afecciones Urinarias*, November, 1890.)

Dr. Brocq, after consideration of a case where syphilitic reinfection was in question, makes the following deductions:

1. It is necessary to obtain all the facts required before publishing under

the name of syphilitic reinfection an observation destined to prove the reality of this infection.

2. There may suddenly appear in syphilitic persons, a long time after the chancre has healed and they have been free from any specific eruption, a chancriform lesion with voluminous and indolent adenopathy, and multiple and unsystematized cutaneous eruptions, scattered here and there without order, simulating papulous and papulo-crustaceous lesions and cutaneous plaques of the secondary period. PICK AND PRITCHARD.

Book Reviews.

Internationaler Atlas Seltener Hautkrankheiten—International Atlas of Rare Skin Diseases—Atlas International des Maladies Rares de la Peau. Edited by Malcolm Morris, London; P. G. UNNA, Hamburg; H. LELOIR, Lille, and L. A. DUHRING, Philadelphia. III. and IV.

We have received the third and fourth fasciculi of this superb Atlas, containing seven chromo-lithographic plates, illustrating a variety of rare forms of skin diseases. The diseases which have been figured thus far in this Atlas are so exceedingly rare that few of the names by which they are designated have a recognized place in dermatological literature. This fact may be accepted as furnishing an additional argument, if any were needed, of the necessity of a thorough revision of the nomenclature and classification of skin diseases.

The superior quality of the plates and the admirable plan of arrangement followed by the different writers in the preparation of the text were favorably commented upon in our notice of the first two numbers. In the plates before us the same high standard of artistic excellence both in coloring and drawing has been maintained.

Plate No. VII. of the series, entitled *Dermatite Pustuleuse Chronique au foyers à Progression Excentrique*, par H. Hallopeau, represents a remarkable form of chronic pyogenic infection limited to the integument characterized by pustular and suppurative lesions with a curious course of excentric progression. According to the author, it constitutes a new species of disease, only one similar case having been hitherto published.

Plate No. VIII.—*Parakeratosis Scutelaris*, von P. G. Unna. Under this title is presented an admirably executed plate containing eight figures representing the form, appearance, and distribution of the lesions, with the minute characters of the scales. The shield-like shape of the scales has led to the proposal of the above name for the disease.

Plate No. IX.—*Adenomata of the Sweat Glands*, by E. C. Perry, represents an example of this affection characterized by clusters of pale, whitish, solid papules distributed over the forehead, the interciliary region, especially numerous about the alæ of the nose and upper lip.

Plate No. X.—*Acanthosis Nigricans*, by S. Pollitzer, represents the neck, hands, and face of a patient affected with this disease, with three beautiful drawings exhibiting the microscopic appearances of the condylomatous and verruciform lesions which constitute its more characteristic features. Plate No. XI. is another example of the same affection.

Plate No. XII.—*Ulcérations Multiples Phagédéniques de Nature Douteuse*, par Emil Vidal, is an admirably well-executed illustration of multiple

phagedenic ulcerations affecting especially the forearms, ankles, and feet, the ear and nose, and also the buccal cavity, the nature of which was obscure.

Plate No. XIII.—*Xanthoma Diabeticorum* by A. R. ROBINSON is a remarkable illustration of papular and tubercular lesions occurring in a diabetic patient and bearing a marked resemblance to xanthoma. The lesions, several hundred in number, were situated chiefly on the gluteal and lumbar regions, upper parts of arms, and anterior surface of the thighs.

A Practical Treatise on Impotency, Sterility, and Allied Disorders of the Male Sexual Organs. By SAMUEL W. GROSS, A.M., M.D., LL.D., Professor of the Principles of Surgery and Clinical Surgery in the Jefferson Medical College of Philadelphia, etc., etc. Fourth Edition. Revised by F. R. STURGIS, M.D. Philadelphia: Lea Brothers & Co. 1890.

The first edition of this Treatise was issued in 1887, and the call for a fourth edition within so brief a period attests the high value of the work and the favorable estimate placed upon it by the profession. No class of disorders has been so systematically neglected by text writers as disorders of the male sexual system, and this study of impotence and sterility from a scientific standpoint we cordially commend to our readers.

Impotence is considered under the heads of Atonic Impotence, Psychical Impotence, Symptomatic Impotence, and Organic Impotence. While few will agree with the author in the significance which he assigns to masturbation in the etiology of stricture of the urethra, yet his views are, for the most part, sound, scientific, and eminently practical. As causes of sterility are considered Azoospermism, Aspermatism, and Misemission. The abnormal conditions of the semen and the causes which deprive it of its fecundating properties are fully treated. The author by no means shares in the opinion generally held by gynecologists that the causes of sterility reside in the reproductive apparatus of the woman. He thinks that "the husband is at fault in at least one instance in every six."

The work concludes with two short chapters on Spermatorrhœa and Prostatorrhœa.

The additions incorporated by Dr. Sturgis are, in the main, judicious, and materially enhance the practical value of the volume.

Some Urinary Disorders Connected with the Bladder, Prostate and Urethra. Lectures delivered at St. Peter's (in 1890) by REGINALD HARRISON, F.R.C.S., Surgeon to the Hospital, Hunterian Professor of Pathology and Surgery at the Royal College of Surgeons of England, etc. London: Baillière, Tindall & Co. 1890.

No English writer on genito-urinary surgery is better or more favorably known to the medical profession of this country than Mr. Reginald Harrison. His writings all bear the impress of sound clinical knowledge, progressive surgical ideas, and new and original modes of treatment.

The six lectures which form the little volume before us: 1. The Prevention and Early Treatment of Prostatic Obstruction; 2. The Operative Treatment of Advanced Forms of Prostatic Obstruction; 3. Points in the Therapeutics and Hygiene of the Bladder; 4. Hematuria, its Significance and Surgical Treatment; 5. The Early Treatment and Detection of Stone in the Bladder; and 6. Observations on some miscellaneous Points—reflect the latest advances made in our knowledge of these subjects and abound in useful practical hints as to treatment.

Editorial.

THE JOURNAL ILLUSTRATIONS.

In connection with the four plates and other illustrations which appear in the present number, we may be pardoned for referring with some pride to the superior artistic excellence of this department of the JOURNAL.

It is generally recognized that the most elaborate description often fails to convey a clear conception of the characters of cutaneous lesions. A good picture of a skin disease, faithfully reproduced, gives a more accurate idea of the objective appearances than can be derived from a hundred pages of text.

From the first establishment of this JOURNAL it has been the aim of its editors to make the illustrations a prominent and distinctive feature—valuable by reason of the intrinsic interest of the subjects portrayed, and attractive by the superior quality of their execution. It is due the Publishers to state that they have seconded our efforts in this direction in the most liberal spirit and have offered every facility for producing the best class of work, regardless of expense.

In the eight years of its publication there have appeared in this JOURNAL no fewer than thirty-four fine chromo-lithographic plates, eight half-tone plates and eight full-page woodcuts, printed on proof paper with more than one hundred and sixty woodcuts and process pictures in the body of the text.

For the past two years most of the illustrations have been by the half-tone process which gives the best results obtainable in the reproduction of photographic effects.

The catalogue of subjects portrayed is rich in practical interest and variety, representing the rarer forms of skin disease as well as those more commonly met with in practice. Our readers have been presented with a series of illustrations which, taken collectively, would form a large and most valuable Atlas of skin and venereal diseases.

We may justly claim, without invidious comparison, that no other medical journal in this country, general or special, furnishes its readers with such a number and variety of high-class illustrations.

JOURNAL OF
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Original Communications.

LUPUS.[1]

BY HENRY G. PIFFARD, M.D.,
New York.

MR. PRESIDENT AND FELLOWS OF THE ACADEMY:

IN compliance with the request of your presiding officer, I propose this evening to lay before you a few facts and conclusions relative to an affection of the skin which has been brought, at the present time, into considerable prominence through the supposed discovery of a new and efficient means of treatment and cure—I allude to lupus.

In order, however, that we may fully understand the proper limitations that should be thrown around the use of this term, it will be necessary to briefly review the subject from an historical standpoint. This is the more important, insomuch as the name has not at all times been held to embrace exactly the same pathological processes, at one time being permitted to comprehend a greater, and another time a less number of clinical features. In fact it would be impossible, even at the present day, to obtain an absolute consensus among dermatologists as to what lesions and what morbid processes are rightfully entitled to the name of lupus.

If we search the early records of medicine we find that the disease was known to the Greeks under the name of esthiomenos—a term which is preserved even to the present day as the title of certain varieties of lupus affecting the vulva. (The fact of these affections being really lupus has been recently questioned by Dr. R. W. Taylor.)

Celsus employs the term struma, which he describes to be a tumor

[1] Read before the New York Academy of Medicine, April 2, 1891.

in which, beneath a crust of pus and blood, things like small glands arise, which are particularly troublesome to the physician, for they excite inflammation and never maturate properly; and whether they be treated with the knife or by remedies, they generally spring up again by the side of the cicatrix, but most frequently after the use of local applications; hence they are always tedious. We can hardly recognize lupus in the description except from the tendency of the lesions to relapse after removal by the knife or otherwise.

Coming to more recent times, we find Daniel Turner, in his "Treatise of Diseases Incident to the Skin" (1714), making it a variety of cancer, of which he says: "If it seize upon the Legs and Thighs it is termed *Lupus*, the Wolf; for that it is, say some, of a ravenous Nature, and like that fierce Creature, not satisfy'd but with Flesh."

Plenck also (1776) confounds lupus with cancer, and gives a description which is equally applicable to both affections as follows: "TUBERCULUM CANCROSUM, *quod etiam noli me tangere vocatur, est parvum tuberculum in facie, rubrolividum, quod multos annos quietum manet, si vero medicamentis multum irritatur, dolere incipit et in cancrum nerveum faciei obit.*"

Willan, Biett, Cazenave and others, in the early part of the present century, contributed much to our knowledge of lupous affections, but the teachings of Bazin, *circa* 1855, created a veritable era in the history of the disease. This writer boldly declared his conviction that lupus was not a purely local affection, but was simply one of the cutaneous expressions of the strumous or scrofulous diathesis, as these terms were then understood. Hardy, his eminent colleague at the Hôpital Saint-Louis, followed him in this, and in his treatise on diseases of the skin used the word "scrofulides" as a collective designation for the various cutaneous affections which in his opinion were of a scrofulous origin, including lupus among the rest.

The present writer's experience led him to accept the views of Hardy in this regard and to incorporate them in his "Elementary Treatise on Diseases of the Skin," 1876. These notions, however, did not meet with general favor in this country at that time, and, in fact, were severely criticised. The late Sir Erasmus Wilson, probably the ablest and most philosophic dermatologist that ever lived, emphatically expressed his belief in the dependence of lupus on the so-called scrofulous diathesis.

Now on what evidence did these acute observers and able thinkers base their conclusions? Simply on the easily verifiable fact that lupus was so frequently associated with that chronic and usually fatal disease of the lungs which has been known to us under the names consumption, phthisis, catarrhal pneumonia, and pulmonary tubercu-

losis. This association was either by heredity or propinquity, or by the fact that phthisis pulmonalis was the usual termination of long-standing cases of cutaneous lupus. This association, too, was so frequent and so close, that it seemed to the writer impossible to accept any other idea than that which predicated a common underlying cause for both phthisis and lupus, and this view he has constantly maintained and taught for the past fifteen years.

In 1877, he went a step further and declared, in a paper read before the Medical Society of the State of New York, that lupus was infectious, using the following words: "Another peculiarity is its gradual extension and involvement of new regions by an apparently infective process, similar to, but less in degree than, that manifested by cancer. . . . This infective quality is evidenced by the fact, that if a patch of lupus be incompletely destroyed, the disease will most certainly return. . . . A consideration of these two points, namely the extreme viability of the cells, and their infective quality, gives us a clue to their appropriate treatment." (*Med. Record*, July 21st, '77.)

Just two weeks later, Mr. Jonathan Hutchinson wrote in the *Med. Times and Gazette* (August 4th, '77) as follows: "The mode in which lupus extends itself, and more especially the manner in which multiple patches are developed, is well worth of investigation. My impression is, that the processes are by cell infection and very similar to what we observe in cancer."

It seems to me not a little remarkable that the same idea should have found almost simultaneous expression by two independent workers, and in almost the same words.

Three or four years later, Dr. Robert Koch announced his discovery of the bacillus of tuberculosis, and clearly set forth its association with pulmonary phthisis. This in turn was followed by the discovery of an apparently identical micro-organism in one of the forms of lupus and in certain other cutaneous lesions.

Those who, prior to these recent discoveries, had claimed a close association between lupus and pulmonary tuberculosis, arrived at their views by inductive reasoning from clinical phenomena, and should certainly feel under great obligations to Dr. Koch and his co-laborers who so strikingly verified their prior conclusions.

Returning now to the views of Bazin and Hardy, we find that the affections which by almost common consent received the name of lupus, do not embrace all of the lesions included by the latter (Hardy) under the title of scrofulides. This, perhaps, will be made more clear by the following table:

SCROFULIDES (HARDY).

Phlegmonous Erythematous Corneous		Lupus Erythematosus.
Pustular Tubercular	With superficial ulceration	Lupus Vulgaris.
	With deep ulceration	Lupus Exedens.

In reference to the above, it may be stated that the tubercle bacillus has thus far been demonstrated in but one of the above-named affections, namely lupus vulgaris. On the other hand, it has been found in certain lesions of the skin which have not as yet been classed as varieties of lupus. I allude more particularly to the so-called tuberculosis cutis of Riehl, Morrow, and others.

If now we accept the prevailing doctrine, that certain cutaneous affections are the result of infection by the tubercle bacillus, it may be convenient to group them together under the common title of tuberculides, and I take the liberty of placing by their side three other affections in which the bacilli have not as yet been found, but in which I believe they will be; these I mark as doubtful in following table:

TUBERCULIDES.

Phlegmonous scrofulide (Hardy)?
Lupus erythematosus?
Lupus vulgaris.
Lupus exedens?
Tuberculosis cutis (Riehl, Morrow, *et al.*).

The phlegmonous scrofulide or chronic intradermic abscess is a most typically scrofulous affection, and merits more attention than it has hitherto received.

Lupus erythematosus is at present the subject of a discussion as to its right to bear the title of lupus at all; it being claimed by some that it bears no relationship whatever to L. vulgaris. I agree, however, with those who consider it a variety of lupus, and it is unquestionably a scrofulide, using this term in the sense understood by Hardy.

The affection itself was first carefully described by the old French dermatologist, Biett, under the name of *erythema centrifugum;* later it received the name it now usually bears, but quite recently Unna, of Hamburg, has returned to Biett's old name, adding however the prefix *U.*

The lupus exedens, included in the above list, is rejected as a variety of lupus by many modern writers who consider it rather as a

variety of epithelioma. Personally, I have been unable to regard it in this light, and still hold to the views expressed by me some years ago ("Elementary Treatise on Diseases of the Skin," 1876).

There is, however, I believe a much closer connection between epithelioma and lupus in all its varieties than is at present generally admitted, but the evidence bearing on this I will not detain you with this evening.

I shall not allude to the clinical features or nosology of lupus, as these are fully described in the standard text-books; nor will I take up your time this evening with the pathological histology of the affection, as it is a subject broad enough to receive separate consideration.

It is to the treatment of lupus, however, that I will ask your special attention, and in doing so will briefly describe the chief methods that have been in vogue during the past twenty-five years, and conclude with a particular consideration of the results obtained by the plan proposed by Dr. Robert Koch, of Berlin.

Without referring to methods of treatment which have proved absolutely inefficient, we may go back to the observation made many years ago by Hardy, that facial lupus had disappeared after an attack of facial erysipelas. On this he based his substitutive method which consisted in the induction of a severe local artificial inflammation, on the subsidence of which the lupus was found to be cured or benefited. His favorite application for the purpose was an ointment of the biniodide of mercury, which he used in varying strengths, even to the extent of mixing the salt with an equal weight of lard and applying it to the affected parts. The effect, of course, was to excite an intensely acute inflammation, varying with percentage strength of the ointment and the special reactive susceptibility of the patient. The first of these varying factors it was of course easy to determine, but the local reaction that was likely to follow a given application was an unknown quantity until after it had been made. In other words, it was impossible to gauge in advance the most desirable potency to employ. If the mercurial ointment were too weak, the inflammation excited would not be sufficient to effect the desired end, but instead would do harm by stimulating a more rapid extension of the disease, for we must remember that a lupus irritated is, like its namesake, a much more troublesome affair than if quietly left at peace. *Per contra*, if an excessive strength were employed, the drug might cause a greater destruction of important tissues and organs in a short time than the disease itself would be capable of doing in several years. The objections, then, to this plan were its uncertainty and general unreliability. Moreover, it was exceedingly painful.

Turning from the substitutive to the destructive methods of treat-

ment, we find that the German plan of boring into the lupus tissue with pointed sticks of nitrate of silver was used to a considerable extent by surgeons in all countries, but is now pretty much abandoned. It was, perhaps, better adapted to the form known as lupus vulgaris than to the other varieties of the affection. It was, however, found to be, in the majority of instances, inefficient. No matter how thoroughly or deeply you plunged the caustic point, a few outlying cells were almost sure to escape destruction, and in a few weeks or months the disease again became manifest. It is this persistent tendency to relapse that makes the affection so rebellious and difficult of radical cure. In the efficient treatment of this disease, the one thing that we must bear in mind is the necessity for the absolute destruction of every portion of the affected tissue. Every cell, every bacillus, every atom or particle of matter capable of conveying infection or of reproducing the disease *in situ*, must be completely destroyed. This fact was clearly apparent to attentive clinical observers before we knew of the existence of the bacillus. Now that we are able to charge this insignificant micro-organism with being the agent of infection, we become more emphatically impressed with the absolute necessity for the complete and thorough destruction of the diseased tissues, if we are to expect immunity from relapse. If we concede that this is the true theory on which to base our treatment of lupus, we have nothing further to consider than the simple question, What is the best *modus operandi* wherewith to fulfil the theoretical demand?

Undoubtedly the first thought that would occur to the practical surgeon would be to promptly excise the diseased tissues, and this is unquestionably the proper course to pursue in certain selected cases. When the lesion is small and favorably situated, the knife affords the quickest and best means of relief, and even in larger lesions, an inch or more in diameter, excision may be employed, provided the neighboring skin can be utilized wholly or in part to cover the wound. In operating with the knife, at least a quarter of an inch of apparently healthy skin surrounding the lesion should be removed, that is, if we desire and expect to prevent relapse. The marginal allowance should be even greater than if we were dealing with an epithelioma, as the lupus infiltration is more diffuse, and branches out more widely and deceptively than in the other affection.

Of the two diseases, the writer has certainly found epithelioma much more amenable to treatment than lupus; that is to say, the relapses after operative interference are less frequent in epithelioma than in lupus. It is a comparatively easy matter to remove a hard epitheliomatous nodule with the knife, cutting through the entire thickness of the skin and dissecting it up from the connective tissue beneath.

With lupus, however, it is by no means so easy; the diseased skin is softened, broken down, and rotten throughout a varying thickness, and is not readily detached from the connective tissue beneath; and on more than one occasion I have been obliged to change from the knife to some other implement in the middle of an operation. The cases, then, of lupus in which the knife is to be absolutely preferred, are greatly in the minority. The majority of cases demand some other treatment.

The direct application of the actual cautery to the surface of the morbid tissue has been frequently employed in the past, but is rarely used at the present time. It was found that relapse was an almost constant feature. The reason for this is not far to seek: the surgeon rarely had the nerve to keep his cautery in contact long enough to destroy the deeper layers of the skin for fear of resulting deformity or injury to neighboring parts. The actual cautery, then, applied superficially is not to be recommended.

Potential caustics, like potassa fusa, Vienna paste, etc., have also been employed, and are reasonably effective when vigorously used, but their action is not under ready control, and they are liable to do unexpected damage.

Some years since, Hebra recommended the use of arsenic applied in the form of paste, claiming that the drug exerted an elective influence on the diseased tissue, while sparing that which was sound. This is to a certain extent true. The arsenic appears to attack the lupous tissue in preference to the healthy, but its action does not seem to be sufficiently diffused, and small outlying cell-collections, beyond the visible margins of the disease, escape destruction. The arsenical application, moreover, is exceedingly painful, and narcotics become necessary for several hours and even days.

In 1870, Volkmann introduced a new method of treatment—namely, the mechanical removal of the infiltration with the curette. The simplicity of the method was its chief charm. The lupous tissue breaks down under the curette like old cheese, and the little spoon removed it without difficulty. The wound healed kindly, and the scar was a good one, that is, as long as it lasted. Radical cure, however, was the exception, relapse was the rule: and the reason for this was clear. As the infiltration is softer than the normal tissue, there is no difficulty in removing most of it in this way, but unfortunately it is rarely possible to do more than this. The still undamaged connective tissue resists the action of the curette and outlying cells escape. Removal of *all* the lupus cells (and bacilli), however, is the necessary condition of ultimate success, and this is not practically effected by Volkmann's operation. In fact, none of the methods alluded to

were capable at a single operation of permanently curing the majority of cases of lupus. A better means of treatment was urgently needed, and the present writer, about the year 1875, sought to accomplish this end by combining Volkmann's raclage with the use of caustics, actual or potential. In 1877, in the paper read before the State Medical Society, I detailed the results obtained in a series of cases treated in various ways, and recommended the use of raclage, followed by the immediate application of the actual cautery, as the means most likely to secure a permanent cure in the majority of cases. It must not be thought, however, that by it the majority of lesions will be cured at the first operation. Many are, but a still greater number exhibit relapses in from one to six months, and will need to be operated on again, and the more extensive the lesions, the greater the probability of their requiring two or more attempts before a permanent result is secured. This combined method, however, of scraping and cautery, has been the one I have usually followed during the past fifteen years.

A few years since, Vidal, of Paris, advocated linear scarifications, but this plan, I believe, has fallen into disuse, owing to the fact that relapse was the rule and permanent cure quite the exception. Quite recently, Professor Leloir, of Lille, has published (*Journal des Maladies Cutanées et Syphilitiques*, Jan., 1891) an article on the treatment of lupus in which he strongly advocates the combination of scraping with the actual cautery, and which he speaks of as his own "mixed treatment," overlooking the fact that it had already been in use in this country for some fifteen or sixteen years.[2]

In carrying out this combined or mixed treatment, I originally advised the most thorough scraping, followed by the cautery at a white heat. Subsequent experience, however, taught me that a red heat was preferable. The white-hot metal causes an instantaneous carbonization of the tissues with which it comes in contact, and which acts as a protection to the deeper parts of the skin, and in this way many of the cells (or bacilli) escaped destruction. The platinum at a red heat, however, burns more deeply, and I now think more thoroughly accomplishes its intended purpose.

During the past year I have practised to a certain extent still another method, which I believe to be original. Briefly it consists in making scarifications and cross-scarifications with a small, sharp-edged

[2] "Je commence par attaquer rapidement, grossierement, brutalement le gros placard lupeux avec une grosse curette de Volkmann, et à enlever aussi le plus de tissu pathologique possible. Puis après avoir pratiqué l'ischémie avec des tampons d'ouate, j'ai souvent pour habitate de cautériser au moyen du thermo ou du galvano-cautère le tissu pathologique restant" (Leloir, *loc. cit.*).

platinum knife heated to dull redness by electricity. With this instrument I cut through the entire thickness of the skin, commencing the incisions in the apparently healthy skin, and carrying them through into healthy skin on the opposite side. The cuts are made as closely together as practicable, and when the lesion is not too large, cross cuts are also made at the same séance. The entire operation may, and I believe should, be performed without the loss of a single drop of blood. This is to be accomplished by the careful regulation of the heat. The platinum knife at a white heat will draw blood as freely as cold steel, but at a dull red heat sears the vessels before it divides them. I am not prepared to advocate this method in preference to the one previously described, as a single year's experience in the use of a particular operation counts for little in this disease.

Of the plans of treatment that have been in vogue, excision and the curette-cautery are the ones which may be practised with the least inconvenience to the patient, and are the ones that are followed with the most speedy results. Excision should, of course, be practised with antiseptic precautions, and when applicable is followed by prompt healing; and the cure will be permanent provided the necessary condition, absolute removal of all the diseased tissue, has been accomplished. When the curette followed by the actual cautery is employed, a perfectly aseptic wound is left. This may be packed with a little sterilized cotton, just as much as the moisture of the part will cause to adhere, and the patient goes about his business without requiring further attention. At the end of ten days or two weeks if the lesion has been a small one, or of a longer time if larger, the crust, which consists of cotton, dried secretion, and carbonized tissue, drops off, leaving a perfectly-formed cicatrix of rosy hue, but soft, smooth, and pliable. Occasionally a little pus forms under the crust before it falls, in which case any convenient antiseptic may be injected under it two or three times a day, until it is detached. In extensive lesions, that is, above one inch in diameter, the crust may be shed before the wound is completely healed. As a rule, the little simple ulcer that is revealed, completely cicatrizes in a few days. When this is accomplished, the inexperienced surgeon—inexperienced, I mean, in the treatment of lupus—is disposed to congratulate himself and his patient on the successful result of the treatment. In a month or two months, or three months or even six months, he may return to the surgeon with clearly-marked evidences of relapse. To effect an apparent and temporary "cure" of lupus is a comparatively easy matter, and may be accomplished in a variety of ways; but the dermatologist knows that a permanent cure will tax his skill and experience to the utmost, and frequently can only be obtained after a number of oper-

ations. When the lesions are small and readily accessible, I believe that in most cases they can be cured at a single séance, but when larger we can rarely hope for more than partial success at the first attempt. The operation, however, should be repeated as soon as the relapsing points can be clearly recognized. The intrinsically treacherous nature of lupus can only be fully appreciated by those who have had much to do with its management.

In the majority of cases I operate without the use of an anæsthetic; but if circumstances demand this agent, we must remember that ether is excluded on account of the danger of fire, and chloroform on well-known grounds. This leaves us protoxide of nitrogen as a general, and cocaine as a local anæsthetic. This latter may be employed by hypodermic injection or by kataphoresis.

Considering now the difficulties that surround the permanent cure of lupus by even the best-devised surgical procedures, it is not surprising that when Koch announced that he discovered an agent that exerted an unmistakable influence on the disease, his assertions should be speedily put to the proof.

It must be clearly understood that Koch has at no time distinctly asserted that his "lymph" would cure lupus, or for that matter any other disease. As a result of his numerous experiments on animals and a few on men, he felt authorized to submit his remedy to public trial by those whose field was in clinical rather than in laboratory work. He, however, made certain preliminary statements as to the results that he had personally observed. These may be briefly referred to.

After an injection of one or more milligrams of his "lymph" in persons free from tuberculosis (or bacillary infection) no change in their general state was observed. The action of the lymph appeared to be nil. If, however, they were suffering from tuberculosis, internal or external, the injection was in a few hours followed by pyrexia of a more or less decided character. After a day or two this subsided, and could again be induced by a renewal of the injection. In those, moreover, in whom the tubercular lesions were on the surface and visible, as in lupus vulgaris, certain very remarkable changes took place. If the lesions were not ulcerated, they became redder and swollen, and in some cases, a serous exudation appeared on the surface. The lupus tissue itself took on a necrotic aspect, and with the dried secretion formed a crust, which became detached in two or three weeks, much after the manner of the crust which follows cauterization, leaving a soft and pink cicatrix. This might occur after a single injection, but, as a rule, several were required to produce the result described. In cases of ulcerated lupus, healthy granulations appeared

and the ulcers gradually cicatrized. These statements by Koch have been repeatedly verified, both in Europe and in this country, and the early reports that we received of the progress in the treatment of lupus by the lymph, were exceedingly encouraging. Patients who had undergone the Koch treatment were discharged almost daily from the general hospitals as "cured." These cases were in the beginning treated almost exclusively by those whose experience lay rather with pulmonary than with cutaneous tuberculosis and who had made a study of tuberculosis in the living, with their ears rather than with their eyes. It is safe to say that very few, if indeed any, of these cases were really cured. In many of them the characteristic "apple-jelly" granules were plainly visible at the time of their discharge from the hospitals, while in the others a few weeks sufficed to reveal unmistakable evidences of relapse. In other words, the patients were no better off than if they had undergone the ordinary surgical procedures after which relapse so frequently occurs. In fact, they were perhaps not so well off, as many cases of lupus have been permanently cured by surgical means, while we do not at this moment know that in a single case treated by Koch's lymph the same result has been obtained. Six months at least, and possibly a year, must elapse before an absolute verdict can be rendered in any given case. When the cicatrix has lost its rosy hue and become completely blanched we may begin to congratulate ourselves on having obtained a permanent cure, and not until then.

The reactions, both general and local, described by Koch as occurring in lupus vulgaris have in the main been verified by subsequent experimenters, but cases have been reported in which there has been general without local reaction, and *vice versa*. In erythematous lupus local reaction has, as a rule, been absent, which gives a certain measure of support to the opinion held by some that this affection is not tuberculous, and not entitled to the name it commonly bears. There have been cases, however, diagnosticated erythematous lupus which have exhibited the reactions common to lupus vulgaris, followed by subsidence of the lesion.

The general statement made by Koch that reactions, general and local, occurred only in those who were suffering from tuberculosis from bacillary invasion whether of the skin or of internal organs, has in the main been verified. This carries with it the corollary that reactions will not occur unless the subject of the injection be tuberculous. This also has in the main been verified. Hence the injection of the lymph may in cases of doubt serve as an aid to diagnosis. Unfortunately these general statements are not absolute, and numerous exceptions have already been noted. We cannot, therefore, place

implicit reliance on the data furnished by the injections in the diagnostic examination of obscure lesions or symptoms.

The remarkable fact, however, remains, that the Koch lymph does certainly produce decided changes in lupus, and changes that are apparently in the direction of cure, and changes that have not been produced by any other medicinal agent at present known to us.

During the last few years, organic chemistry has given us a considerable number of exceedingly active agents that have been largely used as symptom remedies by the profession. We can beat down a fever with antipyrin, we can compel sleep with sulfonal, we can relieve pain with phenacetin, and owing to the energetic action of these drugs we can obtain the desired results with great promptness, and so with a dozen other active agents that might be named. We must remember, however, that we cannot always do these things with impunity. An active drug is always a two-edged sword, mighty for good when properly used, but capable of doing equal damage when handled ignorantly or recklessly. So it is with the Koch lymph. Its administration is not unattended with danger. Three instances have already been reported in which death followed the injection of the lymph for lupus; in one case the fatal event occurred in thirty-six, and in the other twenty-one hours after the first injections, and in both of these the dose administered was well within the limits of safety as assigned by Koch.

The details of these cases were briefly as follows:

CASE I.—(Reported by Jarisch.) A girl 17 years of age, affected with ulcerating lupus of the face, after a single injection of two milligrams was a few hours later seized with a chill followed by increase of temperature, reaching in fourteen hours 41.1° C. (nearly 107° F.). During the following day the temperature varied between 40° and 41° C. In addition, there was repeated vomiting, continual somnolence, involuntary stools, and a very feeble pulse. She died at the end of thirty-six hours.

CASE II.—(v. Burckhardt.) A female suffering from lupus of the face and nasal fossa, with smaller lesions on the lower extremities, received three injections at intervals of three days. The first injection, was 5, the second 8, and the third 10 milligrams. The first two injections raised the temperature to 39.5° and 40°. Four hours after the third, the temperature was 39°, and two hours later at 40.2°, and the patient complained of a sense of weight in the sternal region. This was accompanied with dyspnœa and cyanosis. The urine was scanty and found to contain albumin, which had not previously been present. Death occurred in twenty-one hours (Thibierge).—*Annales de Derm. et de Syph.*, Jan., 1891.

CASE III.—(Service of Dr. Blanc at the Charity Hospital, New Orleans.) A colored boy 17 years old and healthy except for a lupus

of face and neck, received January 15th an injection of .001, January 16th, .002 and January 17, .005. On that day symptoms of nephritis became apparent and he died two weeks later.—*N. O. Med. and Surg. Jour.*, March, 1891.

Other grave though happily not fatal complications following the injection of lymph in lupus are cited by the "*Commission des médecins de l'Hôpital Saint-Louis*" as follows: icterus, albuminuria, hæmaturia, engorgement of the spleen, pulmonary congestion, myo- and endo-carditis (Thibierge, *loc. cit.*).

In all cases in which reaction was developed, the patients have suffered extreme bodily discomfort during the period of pyrexia, varying of course with the violence of the reaction and the susceptibility of the individual.

If we now turn from the practical to the theoretical side of the question, we are met by one striking fact, namely, that we have in the Koch lymph an agent whose physiological action is, so far as I know, unique. Arsenic given in doses capable of producing immediate and striking effects will exhibit them, both in those who are in sound health as well as in those who are diseased; strychnine will tetanize both the sick and the well. Atropine will dilate the pupil whatever the state of the general health, and so with every other active drug that we have occasion to use. The tendency of its physiological or pathogenetic action is the same (excepting of course instances of individual idiosyncrasy). Not so with the Koch lymph. When injected into a person in sound health, it appears to be inert; but if injected into one suffering from either internal or external tuberculosis, we immediately perceive that we are in the presence of an agent of great power, and one whose effects we have as yet no means of controlling. This selective power possessed by the lymph for tuberculous tissue is indeed the greatest mystery; and the most interesting question with which we as physiologists or pathologists have to deal. Is it due to a direct specific influence on tuberculous tissue, or is it due to the fact that the diseased foci are simply less capable than the sounder tissues of resisting the action of the medicament? Unfortunately this question cannot at present be answered.

The changes that take place in lupus tissue under the influence of the lymph are much more readily explained. The result of the injection is the induction of a simple inflammation with the four classic signs, rubor, tumor, calor, and dolor, and the microscope informs us that we have congestion, diapedesis, and exudation. In other words, we have practically the phenomena exhibited by an attack of ordinary idiopathic erysipelas, or readily producible by the biniodide frictions of Hardy

In the few instances, however, that have been reported in which there was little or no local reaction, but in which the cutaneous lesions subsided, we must look elsewhere for an explanation.

It is a well-known fact that many cutaneous diseases will disappear at the onset of acute febrile ailments, and I have myself seen an erythematous lupus fade away during an attack of typhoid fever. We need not then be wholly surprised that the lupus yields in a measure to the repeated pyrexiæ induced by the Koch injections. With the facts as disclosed in this brief review before him, the surgeon is in a position to form his own conclusions as to the desirability or propriety of recommending this method of treatment to his patients. If pressed for my own personal opinion, I can only say that I believe that the surgical procedures heretofore in use are to be preferred to the Koch injections, on the ground of better result, greater safety, and less suffering and inconvenience to the unfortunate victims of the insidious, obstinate, and treacherous disease we have considered this evening.

PERIPHERAL NEURITIS OF SYPHILITIC ORIGIN.*

BY J. A. FORDYCE, M.D.,
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THE infrequency with which neuritis is encountered in the early stages of syphilis has prompted me to report the following cases:

CASE I. *Left Facial Paralysis Appearing Suddenly Four Months After Injection.*—Mr. A——, aged 21 years, consulted me at the Bellevue Out-door Department about the first of September, 1889.

An examination revealed the induration of a recent chancre, multiple adenitis, and a general macular syphilide in its declining stage. He stated that the chancre appeared about four months previously, and that he had not been under treatment.

An exquisitely tender swelling about the size of a chestnut was present at the junction of the middle and outer third of the left clavicle; an intense frontal headache together with rheumatic pains in the right shoulder and elbow were complained of; the temperatrue was 101° F. Hydrarg. bichlor. gr. $\frac{1}{16}$ was ordered and was well tolerated. On September 17th, he returned with a paralysis of the left facial nerve of four days' duration, involving all its branches; the eye could only be imperfectly closed and the muscles of the cheek and lower part of the face were immovable.

A slight impairment of the sense of taste was discovered on the

* Read at the fourth annual meeting of the American Association of Genito-urinary Surgeons.

paralyzed side. The soft palate was found to be normal. No impairment of hearing was detected.

The treatment was continued and the patient directed to report frequently for observation.

At the end of ten days he returned with only a trace of his former paralysis; the eye could be closed in a normal manner and the cheek muscles were freely movable. Natural taste had returned. The headache had disappeared along with the swelling over the clavicle and the rheumatic pains in the right shoulder and elbow.

The involvement of all the peripheral branches of the nerve would exclude a central lesion, while the disturbance of taste would point to a localization of the lesion within the Fallopian canal near the point where the chorda tympani is given off.

Of course it was impossible to determine the nature of the lesion with certainty, but from the simultaneous occurrence of syphilitic swellings of the periosteum in other localities, one would be justified in concluding that the nerve fibres were compressed by a swelling of its sheath within the narrow Fallopian canal. This supposition was strengthened by the transitory duration of the affection and its disappearance along with the other osteocopic pains of the early secondary eruption.

The relationship of cause and effect between the general disease and the local affection is open to the criticism that facial paralysis is a frequent affection, while its occurrence during syphilis is much less so.

A number of writers have, however, noted the coincidence of the two affections, among them the following:

Rumpf[1] observed a facial paralysis in connection with an affection of the acoustic nerve in a syphilitic patient. The specific nature of the nervous affection was, however, subject to doubt.

Steenberg[2] reported the case of a patient in whom a left facial paralysis occurred with the early secondary eruption, without headache, vertigo, or other manifestation of a central trouble.

The eruption was treated for five weeks with mercury, at the end of which time the paralysis had improved.

The case of Vidal (de Cassis)[3] resembles the one reported by me in that the facial paralysis appeared at the time of the early secondary eruption and was accompanied with disturbance of the sense of taste.

Cruveilheir[4] observed, along with a neuralgia of the trigeminus in a syphilitic subject, abnormal sounds in the ear of the same side and within a few days a paralysis of the facialis. Examination revealed an anæsthesia of the same side.

Van Buren and Keyes[5] have reported a case occurring during the second month after infection.

Ljunggrén,[6] in an elaborate and well-written article, reports, among a number of cases of cerebral affection in the early period of syphilis, four cases of facial paralysis involving the muscles of the face and tongue with the exception of the frontal portion of the nerve.

All of these cases were ushered in with intense headache and vertigo, and are without doubt to be referred to a central rather than a peripherial affection of the nerve. The meningeal irritation and inflammation which Lang[7] described in early syphilis, accompanied at times with inflammation of the retina and choroid, could, when localized at the origin or along the course of the nerve, easily induce a paralysis of a more or less severe grade and of transitory duration.

The well-known anatomical situation of the cranial nerves to their canals of exit, and the especial liability of the cerebral membranes and cranial bones to late syphilitic lesions, is the general explanation given of the paralyses of the cranial nerves so often encountered in this disease. An interstitial neuritis caused by the direct action of the virus on the nerve fibres, as in leprosy—a disease with which, in many respects, syphilis presents points of similarity—is seldom encountered.

The following case came under my observation in 1884 at Hot Springs, Ark., having been kindly referred to me by Dr. Garnett, of that place:

CASE II. *Multiple Neuritis of the Lower Extremities Coincident with the Early Erythematous Eruption of Syphilis.*—J. B., aged 40 years, lawyer by profession, came to Hot Springs for the purpose of receiving treatment for a recently-acquired syphilis. He had been addicted to the moderate use of alcohol. He stated that about ten weeks previously he had observed a sore on the penis, which was followed by a general rash two weeks before he came under my observation. At the same time he noticed some weakness of the legs; they appeared to be heavy and difficult to move and were the seat of dull, aching pains. The weakness increased until a few days before he reached the Springs, when he was unable to stand erect or to make any attempt at locomotion.

An examination revealed the following condition of the patient: The induration of a recently-acquired sclerosis was present on the prepuce; in both inguinal regions and in the post-cervical region the characteristic adenopothies were found. A universal macular syphilide was present in its florid stage. The nervous phenomena presented by the patient formed the interesting feature of the case, and at that time excited my interest in a high degree. The patient when seen was confined to bed, and unsupported attempts to walk were followed by reeling and, if not prevented, by falling to the floor. He was able, however, to move the legs about in bed quite freely. Below the knees

the muscles were exceedingly tender to touch or deep pressure; the tenderness was not localized along the course of the nerves, but was irregularly distributed over the muscles, being especially observed in those of the calf. Numbness of the feet and lower half of the legs was complained of and tactile sensation was impaired in these localities. Muscular power was markedly affected, he being unable to overcome even moderate resistance applied to the muscles of the anterior part of the thigh. The patellar-tendon-reflexes of both sides were absent. Electrical examination made four weeks after the onset of the paralysis showed loss of excitability of the nerves and partial reaction of degeneration in the muscles. At the same time the muscles of the lower extremities, especially those below the knees, showed a distinct atrophy which advanced with the progress of the disease. The functions of the bladder and rectum were unimpaired and continued so during the patient's illness.

The special senses were normal. No pain or numbness were complained of in the upper extremities and no soreness was present on muscular pressure. The treatment was that usually employed at Hot Springs—the mercurial inunctions—the patient was directed to use ʒ i. daily of the ungt. hydrarg., which was continued for a period of six weeks, with occasional interruptions owing to the occurrence of mercurial stomatitis. At the termination of this period the syphilitic eruption had almost disappeared. The paresis of the lower extremities, however, showed no improvement; on the contrary, the muscles had undergone farther atrophy. Iodide of potassium was added to the mercurial treatment in increasing doses until the patient consumed 300 grains daily. After several weeks' use of the iodide in connection with mercurial inunctions and daily bathing, a gradual improvement took place, the muscular pains and soreness abated, and after the daily use of massage and galvanism for a period of several weeks longer, the patient was enabled to walk by the aid of crutches. From this time the improvement was rapid, and he departed for home at the end of four months from the onset of his illness with the muscular power in the legs almost entirely restored.

The diagnosis of a multiple neuritis affecting the nerves of the lower extremities was probable, as the non-implication of the bladder and rectum together with the electrical reactions of the muscles and nerves would exclude a pathological condition in the spinal cord.*

*After this paper was written I found that Dr. Mills had presented a communication before the American Neurological Association in 1887, in which he described a number of cases of paralysis which occurred in patients who gave a clear history of syphilis or alcoholism, or both, the clinical features of which correspond to those presented by my own case. It was not always possible to separate the purely alcoholic from the purely syphilitic

In the voluminous literature concerning multiple neuritis which has appeared during the past ten years very little is written as to syphilis among its causes.

Leyden[8] had never seen a typical case of syphilitic neuritis of the lower extremities, but had observed a young man who presented himself during the florid stage of syphilis with pain in and paresis of the muscles of both arms, together with muscular atrophy and the reaction of degeneration. He attributed the nervous disturbance to the specific disease, as nothing in the patient's occupation or habits could be invoked to account for the trouble.

In the following case reported by Buzzard[9] neuritis of a large number of the peripheral nerves was present, resulting in almost complete paralysis. The patient, a man aged 44, came under his observation in the following condition: "He had double facial paralysis, total absence of the power of voluntary contraction in the muscles of either leg, the grasp of both hands almost entirely lost, and partial paralysis of respiration and deglutition. There was incomplete paralysis of the right external rectus muscle and of the soft palate, especially on the left side. There was little movement of the diaphragm, and the intercostal muscles were acting so imperfectly that the patient could not lie down in bed. Cutaneous anæsthesia was more or less general throughout the trunk, extremities, and face, the tips of the fingers being especially numbed.

"The power of the sphincter ani was normal, that of the bladder impaired to a slight degree. The muscles about the mouth showed the reaction of degeneration. In those of the arms the reaction to faradism was greatly diminished, while in those of the legs below the knees it was quite absent. In no part of the upper or lower extremities was there increased action to slow intermissions of the galvanic current. In the face, however, this was marked. His attack had commenced one month previously with numbness in the finger-ends, followed on the same day by weakness in the legs, which increased next day and was then accompanied by numbness about the calves, thighs, and buttocks. As there was a syphilitic history, he was treated with iodide of potassium and later with mercury. He soon began to improve, and after six months was able to resume his occupation; a few months later he was entirely well."

As the cases of multiple neuritis which have followed the acute

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cases, but he presented the notes of three cases in which the past history and the results of treatment indicated a syphilitic origin of the affection. The writer was uncertain whether to locate the trouble in the peripheral nerves, in the cord, or in both regions, as the present rules of diagnosis were clearly inefficient.

infectious diseases, diphtheria, scarlet fever, measles, typhoid fever, etc., pursue an entirely different course from the original complaint, they are, according to Leyden and Rosenheim,[10] to be referred to the action of the chemical poison—the ptomaines—generated by the disease germs rather than to the direct action of the bacteria on the nerve fibres. Whether this explanation would apply to syphilis or whether it, like leprosy, owes its neuritis to the direct invasion of the bacilli into the nerve tissue, must remain a matter of speculation. The tardiness with which my patient responded to the action of the specific remedies might be used as an argument against the direct working of the microbes. Still when we recollect that time is required to restore a degenerated nerve fibre the objection loses much of its weight.

It is doubtful whether to refer the localized analgesia to which Fournier[11] has called attention as often present in early syphilis to a central or peripheral affection of the nerves. Lang speaks of pain, anæsthesia, and weakness in the legs occurring with the first general syphilitic outbreak, and as such symptoms generally disappear under mercurial treatment, he feels justified in referring them to an irritation of the spinal meninges analogous to the irritative processes in the cerebral meninges which he had observed.

A few cases of primary interstitial neuritis of single spinal nerves have been reported both in the early and late periods of syphilis. Delafield[12] records the case of a man aged 46 years who was infected with syphilis five years before he presented himself with pains in the lower extremities, and no other symptoms until two months before his death, when he developed weakness in his legs, involuntary discharges from the bowels, and difficult urination; nodes were present on the skull and right tibia; death took place from an intercurrent erysipelas. An autopsy showed that the spinal cord was unchanged, while the large nerve trunks which comprise the *cauda equina* were the seat, two inches from their end, of a pea-sized yellow cheesy tumor which inclosed several spinal nerves, and to which the dura mater was adherent; two inches lower down several other nerves were adherent and degenerated.

Ehrmann[13] cites the history of a patient in the ninth month of the disease, who, when he was received into Professor Neumann's clinic, presented evidence of recent cutaneous syphilis together with a periosteal swelling of the left external malleolus and of the dorsal surface of both feet. A painful swelling of the phalangeal joint of the left ring finger was further observed. Anæsthesia along the ulnar side of the left forearm and sensibility to pressure along its entire course were noted. Pressure along the branches of the nerve and also along the median elicited pain. The nerves of the affected side were more easily

felt than on the healthy side. The muscles of the thenar and antithenar eminences supplied by the ulnar nerve were atrophied, as was the opponens pollicis supplied by the median. Hyperalgesia was present in the skin supplied by the ulnaris and median cutaneous nerve, and the electrical excitability of the nerve was diminished. Under the use of the iodide of potassium the atrophy, anæsthesia, and pain on pressure disappeared.

Hutchinson [14] quotes the case of Dr. Ormerod, published in the Pathological Transactions, of a woman aged 23, the subject of inherited syphilis, who presented a fusiform enlargement of the left median nerve in the middle of the arm. The tumor was tender on pressure. It had been present for nearly three years and was attended by motor paralysis, wasting, and anæsthesia. The patient presented several unequivocal signs of congenital syphilis.

Bowlby [15] observed a patient, aged 54, who had suffered from syphilis for many years, in whom a gradual paralysis of the parts supplied by the ulnar nerve commenced ten years before he came under the author's notice.

The hand was clawed, the interossei muscles and those forming the ball of the little finger extremely wasted, together with well-marked atrophy of the ulnar side of the forearm. The skin supplied by the ulnar nerve was quite anæsthetic. The nerve could be felt behind the elbow as a thick, hard cord, not less than four or five times its natural size, the thickening extending along the trunk for about two inches.

Unna [16] has observed in late secondary syphilis certain erythematous and papular skin eruptions of a circinate outline which are not influenced by antisyphilitic treatment, and which, by reason of their analogy to the macular lesions of anæsthetic leprosy, he is disposed to regard as trophic in character, the result of an interstitial neuritis of like character to the interstitial neuritis of leprosy caused by the entrance of the bacilli lepræ into the nerve trunks.

It would appear from the foregoing that interstitial neuritis resulting from syphilis is one of the rarer manifestations of the disease, but that it may occur both in its early and late stages and affect one or more nerve trunks.

A typical multiple neuritis resembling that which follows the acute infectious diseases must be of more unusual occurrence. It should be encountered early in the course of the disease, while the poison is in its most active state and disseminated throughout the general circulation. At present, however, the cases reported are too few in number to permit any general statements regarding them.

Considering the predilection which the disease shows for the nerve

centres later in its course, it is surprising that the nerve trunks are not more frequently affected; in this respect presenting a striking contrast to leprosy, which spares the more highly-organized centres, finding in the peripheral nerves a more suitable soil for development.

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66 PARK AVE.

CARCINOMA LENTICULARE—CANCER EN CUIRASSE (VEL PEAU)—REPORT OF A CASE.

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ON the 12th of March, 1890, Mrs. F., aged 55, of Pratt Mines, near Birmingham, Ala., came to me presenting the following history and symptoms: Duration of the disease was about two years. She had first noticed a "hard lump" in the skin of the left breast. About the same time "red spots" appeared in the skin of the left mammary and pectoral region, followed by similar condition on the right breast. In these "spots" papules and tubercles were formed and the skin became diffusely infiltrated. A gland in the left axilla became enlarged and "tender" a few weeks ago. She could not state how long other enlarged (cervical) glands had been so.

At present the skin of the entire anterior thoracic region is involved, the left side, however, more extensively than the right. The right

mammary gland is decidedly indurated, the left apparently so, but the skin is so hard, dense, and adherent that the real condition of the gland is difficult of determination. The skin over the gland is quite immovable. Deeply set in this densely-infiltrated skin of the thorax are numerous tubercles and nodules, studding the surface. External to the lateral borders of infiltration are a few isolated tubercles and nodules, circumscribed by normal-looking skin. Some of these are elevated and of purplish color; one is umbilicated, others are depressed; the cutaneous covering is movable over them, and they feel like pieces of cartilage set in and occupying the subcutaneous tissue. The color of the "older" portions of the diseased surface is a purplish to dirty-gray, shading off, in a few newer, isolated lesions, to that of the normal skin. The areolæ of the nipples are infiltrated and slightly scaly, and the nipples are similarly affected, but are not retracted. In the more densely infiltrated area the subcutaneous tissue is as completely involved as the skin, but many of the solitary lesions seem confined to the skin and are freely movable. The tubercular or nodular lesions, both in the infiltrated and non-infiltrated skin, vary in size from a pin-head to that of a small cherry. Many of the larger nodules have in their summit a peculiar round, shot-like, waxy-looking formation. A few dilated vessels can be seen on the surface of some of the lesions. Just beneath the left clavicle there is a reddish, waxy-looking, very hard growth the size of the finger-tip, the summit irregular and showing one or two dilated vessels—the whole appearance suggesting epithelioma. The infiltrated portion is limited below by a line corresponding to the border of the diaphragm, and the edge is as sharply defined as that of a board. The clavicles roughly form a line of limitation above, while a line dropped from each axilla would define the lateral limits.

On the inner surface of the left arm, which is œdematous, an irregular-shaped, deep red, non-elevated patch is seen, very itchy and scaly from scratching. The patient says this is the characteristic appearance and sensation of the skin when it is first invaded by the disease. On the back are two or three similar patches, in one of which slight infiltration appears to have already occurred. Just to the left of the external border of the left scapula is a bean-sized, roundish lesion, smooth and of pinkish color, surrounded by skin of normal appearance, none of the "primary redness" of skin being present. (This lesion was excised for microscopic examination, and seemed limited to the corium.) As the disease progresses in the above-mentioned red patches itching is succeeded by pain and a sensation of heat. There is also pain in the breasts. There has not—to this time—been the slightest ulceration in the diseased tissues. Anterior cervical glands are enlarged and hard. Right axillary not involved. Patient has lost a little in weight, but has none of the look of "cancerous cachexia." The only general symptoms are constipation and "dyspepsia."

She is the mother of four children, the youngest now twenty-four years old. During lactation with her first child the right breast became inflamed, suppurated, and was incised.

The patient returned home in two days. Naturally the prognosis was unfavorable, and the only treatment which seemed to be indicated was that directed toward the general health of the patient. Some months later I learned that practically no treatment had been followed. Under date of January 5th, 1891, Dr. G. W. Brown, of Pratt Mines, wrote that ulceration took place in older portions of diseased surface soon after the patient returned home, and "the nodules increased in number and extent." She became addicted to the opium habit and died about December 1st, 1890.

Microscopic Examination.—The above-mentioned specimen was hardened in alcohol and imbedded in celloidin. Sections were stained with "borax carmine" and hæmatoxylin solution, the best picture being obtained with the former. Epidermis normal. In papillary layer of corium a few isolated, scattered connective-tissue and round cells, as may be seen in slight inflammation. About hair-follicles there are collections, in groups, of small cells, round, spindle, or irregular in shape. At some points in the papillary layer there are compact groups of, chiefly, round cells, in which no blood-vessel or capillaries can be seen. The sweat-ducts seem free. The whole system of cutaneous vessels is more or less affected. The papillary branches, the superficial and the deep plexus and their connecting branches are surrounded or completely enveloped by small round cells, among which are seen a few of the spindle variety. These cells invest the vessels in a thin layer throughout their course or expand into groups. The "groups" are especially numerous about the papillary branches. Every visible branch in the field has its cell accompaniment. A little above and also at the level of the sweat-glands are cells of a different type and larger, round, oval, or polygonal in shape, and either in "bands" or roundish groups closely confined by connective tissue. The cell nucleus is clear, and an occasional nucleolus may be seen. These bands and groups of cells, with their connective-tissue covering, are so arranged as to form a somewhat reticular image. In many of these are to be seen, probably around a capillary, small cells of the type already mentioned. The character and arrangement of the large cells is such as we usually see in tissues just becoming infiltrated with carcinomatous disease.

The sweat-glands proper were normal, save for the presence of the small cells accompanying their nutrient vessels.

A specimen from an older portion of the disease might have been better, but I believe the one obtained gave a sufficiently clear aid to reaching the diagnosis made.

I will admit that I first believed the disease to be sarcoma, being influenced by the macroscopic as well as by the microscopic appearances (condition of the blood-vessels), and especially by the "primary" redness in areas of beginning disease. A portion of Funk's (*Monats-*

hefte für prak. Dermatologie, Band VIII., Nos. 1 and 2) description of cutaneous sarcomas fits this case fairly well. He says, under "Early Forms, Primary Efflorescence:" "*a.* A yellowish-red, red, brown- or bluish-red, generally pea-sized macule. Many of these are produced wholly from small tortuous vessels, many are hemorrhagic. The onset of skin sarcoma may frequently be confounded with purpura. *b.* A millet-seed-sized smooth papule may arise from the macule or its border." Under "*c*" he says: "The tubercles of sarcoma are generally pea-sized, 'level' (more rarely hemispherical), hard and smooth, dark bluish-brown color. Recent tubercles frequently translucent with tortuous vessels on the surface, of bright color, lesions becoming darker gradually as result of exudation of blood. Older tubercles frequently of blackish-violet color." Under "*e.* A diffuse infiltration of the skin," he says: "The affected part is slightly raised, of a bluish-red-brown color, hard, board-like, and not at all or only slightly flexible. Diffuse infiltration generally involves the subcutaneous connective tissue also."

Crocker ("Diseases of the Skin," 1888) gives the symptoms of carcinoma lenticulare and the stage answering to Velpeau's cancer en cuirasse, and quotes the typical case published by Morrow and Robinson in this JOURNAL in Vol. II., p. 1, 1884. This description so well covers the symptoms seen in my case that quotation of further authorities would be superfluous. My memory of Funk's description first led me to think of sarcoma, and then Crocker's induced a further study of the symptoms; and microscopic appearances led to the discovery of the carcinomatous nature of the disease and to giving the age of the patient, the enlarged lymphatics, and the epitheliomatous character of one of the lesions their full share in the symptomatology.

16½ WHITEHALL STREET.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

206TH REGULAR MEETING.

DR. E. B. BRONSON, *President, in the Chair.*

Epithelioma of the Nose Treated by Bougard's Paste and Pyoktanin.—Presented by DR. ALLEN with the following history:

The patient was first seen about two months ago, when an epithelioma the size of a small Mandarin orange occupied the region of the nose. (Photograph shown taken February 10th.) The growth had first shown itself one and a half years ago, after a nodule on the bridge of the nose had been irritated. As the patient refused operative measures, the arsenical and chloride of

zinc paste recommended by Dr. Lewis was applied over limited areas at a time, until by the end of February the growth was entirely removed, leaving an ulcerative surface. Under aristol in five-per-cent ointment and application of the dry powder once daily, healing took place over about one-quarter the area. Evidences of cancer being still present, a 1 to 300 solution of pyoktanin has since been applied, with some further signs of improvement.

DR. LEWIS hoped that Dr. Allen would make another application of the paste, as there was yet evidence of existing disease. The case was almost identical with one treated by himself in the same manner, and which at first appeared to be incurable. A complete cure was, however, obtained by the remedy.

Lupus of the Hand.—Presented by DR. ALLEN, and regarded by him as identical with the tuberculosis verrucosa cutis of Riehl. The patient was a boy of 17, in whom the disease had existed for ten years, leaving cicatricial tissue in the centre, while the lupus advanced in all directions at the periphery, extending upon the backs of the fingers. Some benefit had resulted from a local injection of the chloride of gold and iodide of manganese solution of J. Blake White, but a severe dermatitis and cellulitis had been occasioned by it. The patient had then received five inoculations with tuberculin, all followed by local and general reactions. Finally, Dr. Allen had injected locally into the patches themselves one milligramme of tuberculin six hours before the case was presented and local tenderness was already present in the lesions. So far as he was aware this was the first case of lupus in which tuberculin had been employed in this manner. The treatment had so changed the appearance of the disease that in its present condition a diagnosis would not be easily made.

DR. ELLIOT said that inasmuch as lupus tubercles were present in the scar tissue and at the periphery of the patch, he could not regard it as a case of tuberculosis verrucosa cutis of Riehl and Paltauf, but as one of lupus vulgaris.

Prurigo.—Presented by DR. SHERWELL.

Minnie, aged 6½ years; born in America; parents of German descent. The eruption now present was noticed when she was about two years old. Though benefited sometimes by treatment, it has been present since that time. The eruption is confined to the extensor surface of the extremities; it itches intensely and is attended with some thickening of the skin of the lower extremities. The treatment has consisted of local applications of an emulsion of bitter almonds with bichloride of mercury.

DR BULKLEY had seen a number of such cases, which proved afterward to be cases of papular eczema. He could not find the characteristic papules of prurigo nor glandular enlargement in this case. He regarded it as doubtful whether prurigo existed in this country as frequently as supposed by some members of the American Dermatological Association.

DR. JACKSON said that the presence of lesions in the flexures of the joints spoke for papular eczema rather than for prurigo.

DR. ELLIOT did not consider the case one of prurigo, but of a chronic pruriginous papular eruption, which he had always called papular eczema. In this patient there was no thickening of the skin, no pigmentation, the hairs were healthy and well nourished, the skin between the lesions perfectly normal, all except the last features present in prurigo. If it were this latter dis-

ease, then he had seen many cases of it here, and had even found it easy of cure. He saw patients frequently with symptoms entirely identical with those of this child, and they would get perfectly well and remain well for years. Such was not the case in prurigo.

DR. FOX was quite sure that the case presented was an example of the prurigo mitis of Hebra. He had seen many such cases at the Vienna clinics, and as nearly as he could remember, this was a case which accurately corresponded to them. The localization of the disease and its long persistence in spite of treatment spoke strongly for prurigo.

DR. BRONSON said that, according to his experience when in Vienna, practically much less was made of the papule there than in the literature of the subject. In all the cases that he had seen there, the only features on which stress was laid were the localized pruritus, the roughness and thickening, together with various trophic lesions of certain regions of the skin. He had never had pointed out to him, so far as he could remember, a prurigo papule. In cases of pruritus hiemalis that have lasted for several months, nodules were found which were as characteristic as any prurigo papules. He believed the same lesions would occur in every case of persistent itching, attended with scratching, where the skin did not succumb to the ordinary forms of inflammation.

DR. SHERWELL said it was to be remembered that the child had had this persistent eruption since the age of two years—always of a discrete, hard papular character. The eruptive fevers, notably the measles, through which she had lately passed, had not changed their character or sites.

While the adenopathy in the groins was not marked, still it was present. He did not present the case as one of prurigo ferox, but one of the milder types of the disease. There had never been present any patches of eczema under any provocation or any weeping of the papule. Taking all these things under consideration, he was not inclined to change his diagnosis, and thought that time would confirm it.

Papular Syphilide and Seborrhoic Eczema.—Presented by DR. ELLIOT.

Male, aged 29; had initial lesions in November, 1890. In January, 1891, sore throat, headache, lumbago, and a severe cold. Soon after (a week or two) an eruption of papules appeared on face, and then more or less over the body. Has had for a long time pityriasis capitis, which has led to partial baldness. Patient was first seen by me on March 13th. The eruption was found present over nearly the entire body. On the face and scalp were large discrete papules; on the body groups and patches of miliary papules of all sizes, the individual lesions situated around a follicular opening, indurated, brown-red in color; many dark pigmented patches here and there, where similar patches had been. On the extremities, as well as the body, there were also simple lenticular papules and patches of miliary lesions. The palms were also implicated. Besides the lesions noted, there were numerous others distributed more or less widely between these over the trunk and extremities.

These lesions on the arms and other portions of the body were round, oval, and irregularly shaped, of all sizes, from a small finger-nail to a silver dollar and larger. They were not infiltrated, but very superficial, yellowish-red in color, slightly scaly, especially around their peripheries. On the sternum and in the interscapular space the patches were large, irregular in shape, yellow in color, and covered with soft, fatty scales and small crusts. The itch-

ing was complained of very greatly, and became so severe at night that the patient could hardly sleep.

The patient was given hydrargyri bichloridum gr. $\frac{1}{24}$ *ter in die*, and a salicylic acid ointment was applied. The lesions of syphilis began fading, but the pruritus continued the same. On March 16th a 3-per-cent ointment of resorcin was used: the itching subsided so that he was able to sleep, and has continued diminishing in proportion as the eczema seborrhoicum has undergone involution.

Case for Diagnosis.—Presented by DR. BULKLEY.

The patient was a woman, aged 45 years. The eruption began nine years ago, after the birth of her first child. It appeared in the beginning on the anterior surfaces of the legs, just below the knees, as minute red spots, over which scales would collect. Itching was distressing. It next appeared over the extensor surfaces of the arms and elbows.

The trunk was not involved until a number of years later. The disease disappeared three or four times under treatment.

At present the body is almost completely covered with the rash. It extends from the wrists to the shoulders, covers the breast, back, buttocks, thighs, legs, and the dorsal surfaces of the feet. The nails of the hands and feet are brittle.

The diagnosis rested between chronic general psoriasis and lichen planus.

DR. ALLEN had treated a case of well-marked psoriasis which, on disappearing, had left patches of lichen planus, which subsequently underwent further development. He would be inclined to think there was a combination of psoriasis and lichen planus in the present case.

DR. KLOTZ thought the case presented more the features of pityriasis rubra pilaris than of lichen planus or psoriasis.

DR. FOX had seen the patient several months before, when she presented a typical psoriasis. He would attach little importance to the flattened papules about the neck and shoulders which were present, as the same appearances were encountered in eczema, and in both chronic psoriasis and eczema the normal furrows of the skin were exaggerated. The case presented more points of similarity to pityriasis rubra pilaris, though he was convinced it was a psoriasis. The color of the eruption was characteristic of psoriasis, nowhere assuming the violaceous hue which was almost invariably present in lichen planus.

DR. ELLIOT said that when he first saw the case he had made a diagnosis of psoriasis, and only a few days ago, after the patient had been under an alkaline treatment and the individual lesions had become more discrete, had he made a diagnosis of lichen planus. At the margin of the hair on the forehead, and especially on the neck, the lesions were very typical and arranged n rows which ran in a cross direction to the cleavage lines of the skin, a fact which he had observed in lichen planus and not in other diseases. A number of isolated papules were also present over the chest and neck and upper arms, which were typical of lichen planus. He had seen many cases of the disease in which the color of the lesions was not purplish, but red, and even pink. The color depended especially upon the acuteness with which the disease developed. Treatment directed against psoriasis had been apparently without avail in this case. Tar preparations had proved exceedingly irritating, while Unna's ointment had quieted the itching and improved the disease wherever it had been applied.

Dermatitis Papillaris Capillitii.—Presented by DR. BRONSON. The patient was an Italian, aged 32 years. Three years ago he noticed a pimple on the back of his neck; it itched very much, but was not tender to the touch. Four months after it enlarged to almost its present dimensions.

One year ago he noticed the appearance of small nodules about the hair of his beard, especially beneath the chin (see cut). At present he has several

oands of keloid-like growth situated at the back of his neck and involving the hairy scalp. A number of minute hard tumors are also seen at the sites of the hair-follicles of the beard.

DR. ALLEN thought the lesions on the back of the neck and those in the beard were unlike. He had often seen in the colored race just such nodules about the hair of the beard in those who shaved "close."

DR. FOX referred to a similar case, a negro, presented by him to the society about six months before, in which the same condition was present at

the back of the neck and also about the hairs of the beard. Some years ago he made a diagnosis of dermatitis papillaris capillitii in a case which subsequently was seen by Kaposi, who confirmed his diagnosis. He was convinced that the cases of this affection were keloidal from the beginning, and was confirmed in this view by the microscopic investigations of Dr. Heitzman. He regarded the tumors in the beard and those of the occiput as identical.

DR. ELLIOT believed that the process was not limited to the back of the neck and scalp, but occurred also on other parts of the body. He had had for a long time under treatment a patient who presented over the sternum and back, as well as on the sides of the neck and arms, lesions which at first resembled large papules of indurated acne, but they did not become pustular. In their course they appeared to undergo a fibrous degeneration, and formed keloidal growths of various sizes, which persisted and grew slowly from year to year. Some of the lesions had been cut out bodily, and though the wound healed by first intention, subsequently keloidal degeneration of the scar ensued. In this case the lesions resembled in every particular those found in dermatitis papillaris capillitii.

DR. BRONSON said, in examining this patient, that he had in mind Dr. Heitzman's paper on dermatitis papillaris, and it was on account of the views therein expressed that he looked upon the affection of the beard and occiput as analogous affections.

Urticaria Pigmentosa.—Presented by DR. GOLDENBERG (by invitation). The patient, a girl, had her first attack of urticaria when she was two years old, and from that time to her fifth year she had repeated attacks. When five years old her mother noticed yellow spots over the body, more pronounced in summer than in winter. She does not know whether or not they appeared at the sites of the urticarial lesions. The eruption is distributed over the face, extremities, and trunk, the palms and soles only being free.

It changes color when the child is excited, and is itchy at times. When the child scratches herself she produces an urticaria at the site of the pigmented spots.

An Anomalous Case of Alopecia for Diagnosis.—Presented by DR. GEORGE T. JACKSON.

Louisa ——, 15 years old; German-American; has had an attack of this disease every year for nine years. It begins as an eruption of "greenish-white blisters" at the back of the head, from where it spreads to vertex. It is itchy, crusts form, and the hair always falls out. After lasting for a few weeks it gets well of itself under indifferent treatment, and the hair grows again. This s the statement of the patient and her mother, who deny all history of favic crusts.

He first saw the patient some two weeks ago, when the disease looked substantially as it now does. It occurs as an irregularly-shaped patch, with sharply-marked margin occupying the middle part of the vertex of the head. It is of a deep-red color; its middle part is nearly denuded of hair, only having a few tufts in it, and shows a number of small, deep pits, as if the hair had fallen out in chunks; the redness extends under the hair to all sides, and apart from the bald spots, the hair is preserved and does not pull out easily. There is a good deal of moisture, like that of an eczema, and the hair is stuck together. Has seen no pustules about the hairs. There is a well-marked blepharitis, and the girl is stunted and poorly developed.

Were it lupus erythematosus it would not be moist, and it would be apt to occur elsewhere on the face. Moreover, the disease began at a very early age for lupus erythematosus. It is hard to believe it an eczema, as eczema does not produce baldness excepting in young children on the back of the head, where the hair may be rubbed off by constant scratching.

DR. BULKLEY had seen a number of cases of follicular eruption upon the scalp leading to permanent alopecia. He did not think the affection had yet been sufficiently described in the books.

DR. KLOTZ had under his observation a similar case, which did not show, however, the periodical disappearance and recurrence. In this case the eruption was covered with hard dry scales, and upon removing them the follicular abscesses became evident.

DR. CUTLER said that if he had seen the case independent of its history, he would have made a diagnosis of lupus erythematosus with a superadded eczema.

DR. FOX thought it a diffuse inflammation of the skin, possibly neoplastic in character, and the only possible diagnosis that could be made was lupus erythematosus.

DR. ELLIOT said that he understood from the history that there was atrophy of the skin, and yet that the hairs would come back in their normal condition. If there was atrophy, then the latter could not be the case, and if the hairs did return to their natural condition, he did not think there could be atrophy. If, again, this latter did exist, the process, he thought, would be a representative of one of the cicatricial alopecias described by Lailler, Quinquaud, and Besnier; but in his opinion the process on the child's scalp was an eczema, parasitic in nature.

DR. BRONSON regarded the affection as one of the forms of cicatricial alopecia. He could not imagine an eczema so sharply defined. Limited to this region, he considered it either as a new growth or as a parasitic affection.

Dermatitis Herpetiformis.—Presented by DR. BULKLEY.

Andrew J. S., aged 28 years; was first seen in January, 1891. His disease began in November, 1890, as a sudden outbreak of vesicles over the trunk and extremities, attended with burning sensations, but no itching. The vesicles disappeared in a week or two, when the itching began and continued. Lesions on the skin now began as urticarial wheals, followed by groups of papules.

DR. ALLEN would prefer to call the affection an urticaria, from the appearance of the lesions now present.

DR. TAYLOR did not think the inflammatory changes were sufficiently marked to permit the diagnosis of dermatitis herpetiformis. He would desire to eliminate urticaria and pediculosis before making that diagnosis.

DR. BRONSON said the chronicity, the periodicity, and the tendency of the eruption to occur in groups was sufficient evidence on which to base the diagnosis of dermatitis herpetiformis. He saw no special reason why chronic urticaria should not be classed as dermatitis herpetiformis. The main point about dermatitis herpetiformis was that it was a chronic neurosis attended with an inflammatory condition of the skin which manifested itself in grouped efflorescences as herpes did, and whether these efflorescences were papules, vesicles, pustules, or wheals, was a matter of very little importance.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Treatment of Lupus with Koch's Lymph at the Hopital St. Louis, Paris.—The apprehensions to which I gave expression in my previous letter, as to the therapeutic effects of Koch's lymph in lupus, are, unfortunately, confirmed in every particular by the important communications which Messrs. Besnier and Hallopeau have made to the Society of Dermatology and Syphilography of Paris.

I. **Communication of M. le Dr. E. Besnier.**—The most important documents have been presented by Dr. E. Besnier, whose report constitutes a terrible arraignment of the method of Koch.

The number of patients inoculated after having been examined by the commission of the *Hôpital Saint Louis* (Drs. E. Vidal, E. Besnier, Fournier, Hallopeau, Quinquaud, and Lailler) is fifty. In the discussion of these cases Dr. Besnier has set aside twelve, either because they had been inoculated for leprosy or because the treatment has been interrupted or was begun too late to permit them to be entered in line of comparison. He has retained only thirty-eight cases subjected to a special rigorous investigation. As he has said, each one of these cases presents this particular guarantee, that the diagnosis of the lesions has been established by a competent commission, which has followed with the most scrupulous care the phases and incidents of the treatment during its entire continuance and for several weeks thereafter. In order to devote special care to the subjects inoculated and to collect the clinical observations without interruption or break, an extraordinary and permanent guard service night and day was instituted. These documents have, therefore, the characters of authenticity and precision almost absolute.

Dr. Besnier has published a most elaborate and complete synoptical table of these thirty-eight cases (omitted from lack of space). The author has particularly insisted upon the terrible sufferings experienced by these patients as a result of the injections. There has been, however, no case of death to deplore (at least immediate—see farther) at the Saint-Louis Hospital, although many of the inoculated have been in serious danger, and some of them will require a long time to recover from the terrible effects of the tuberculin.

According to Dr. Besnier, two facts dominate the therapeutic history of the Koch method applied to cutaneous tuberculosis: 1. The insufficiency of the local action; the progressive diminution of this action in the course of the inoculations, notwithstanding the elevation of the doses; finally, its cessation, more or less rapid, but inevitable. 2. The intensity of the general phenomena, the gravity of the impression upon the vitality in certain patients, the grave localizations upon the viscera in general and upon the circulatory system in particular; finally, the peril of death, even after small doses in the first, as well as in the series of inoculations. Dr. Besnier remarks that the lymph injected in doses, however elevated, never destroys the tubercle bacillus; it is not parasiticidic, neither does it sterilize the tissues in which the bacillus vegetates. Injected in a patch of lupus, not only does it fail to favorably modify it, but it serves rather to favor in a certain degree the development of the

morbid process. The lupous tubercle is not attacked by the Koch lymph. In all the patients inoculated at the Saint-Louis Hospital not only are found the tubercles which were at first present, but in addition new tubercles evolved during the course of the inoculations.

To sum up, there is produced under the influence of the injections "only a local irritation of an exudative nature, with secondary tendency to atrophy and cicatrization for a time, but an ephemeral tendency, which soon gives place to a revivification of the tubercular nodules probably more active than before."

It is extremely difficult to comprehend the effects of the toxine of Koch upon the organism. The author believes that it acts upon the nerve centres; but it is hardly possible to explain the altogether special susceptibility of tuberculous subjects and of tubercular tissues.

In cicatricial and non-ulcerated lupus the inflammatory reaction which follows the injections takes on an erythematous, erythemato-squamous, erysipelatoid type. In an open lupus this is much more manifest, and is accompanied with a serous exudation, the formation of crusts, and œdematous swelling. There has never been observed at the Saint-Louis Hospital as a result of the injections necrosis and considerable losses of substance. When the inflammation subsides there may be observed "a reduction more or less pronounced of the pathological mass, a diminution in the vascularity of the peri-tubercular tissues, of the 'atmosphere' of the tubercles, properly speaking, then a certain flattening of the surfaces, sometimes a manifest cicatricial tendency, but extraordinary only to those who have not long and attentively observed the normal lupous process."

These phenomena are most remarkable, but they may be quite accentuated without the lupous tubercle itself being destroyed.

The reductions in the volume of the lupus are not always proportioned to the intensity of the apparent reaction; they were here observed especially along the superior border and in regions where the volume of the lesions is increased by chronic lymphatic œdema.

In lupus of the cavities, such as the nostrils and the nasal fossæ, after a painful period of exudation and crusting, there is produced an amelioration characterized by a clearing of the canals. In lupus of the buccal, pharyngeal, and laryngeal mucous membranes there are the same phenomena of congestion, of tumefaction, then of relative reduction, although less marked. But here, as in almost all other lupous lesions submitted to the action of this method, the former condition is soon re-established, which proves that no profound or radical effect upon the tubercles has been produced. In fact, among the patients treated at the Saint-Louis Hospital, even among those most improved, not a single one has for a moment here been considered as cured. The tolerance of the lymph has always been established before a satisfactory result has been obtained.

"In none of those inoculated at the Saint-Louis Hospital has there been obtained a cicatrization of the lupous lesions which persisted behind the nasal orifice, whether atresied or not."

En résumé. The injections of the Koch lymph produced in the lupous foci an irritation variable in type and degree, analogous to the spontaneous erysipelatoid processes so common in lupus vulgaris. Similar to but not more pronounced than these last, "they produced a subsidence of the lesions more or less pronounced, outlines of cicatrization or even cicatrization—a process

of resolution in the congestive atmosphere of the lupus; but the tubercles, properly so called, the essential and specific elements of the disease, remain stationary, or even increase and multiply, as if nothing had occurred." Dr. Besnier adds that a single intercurrent attack of erysipelas places a lupus in a condition of apparent cure much more advanced than has taken place in any of the fifty patients inoculated at the Saint-Louis Hospital.

In none of them was obtained a result superior to or even equal to that which would have been realized by ordinary methods of treatment within the same space of time.

The following are the author's conclusions: "In tegumentary tuberculosis in general, and in all the species, forms, and varieties of tubercular lupus in particular, the inoculation of the Koch lymph produces a local action, the immediate effect of which is a temporary reduction of the mass, a momentary attenuation of the tuberculized tissues.

"Quite marked in all the ulcerated forms of the lupus of Willan, it diminishes in the non-ulcerated varieties, it is still less pronounced in the dry, sclerous, fibrous forms; it attains its minimum in the lupus of Cazenave, all the varieties of which, without exception, are dry and not ulcerated.

"As regards its curative effects, the action of the remedy, even repeated to tolerance, is insufficient to produce a cure in the immense majority of cases; it is neither superior nor even equal in its results to the procedures of ordinary treatment at present at our command.

"In all cases, without exception, however feeble may have been the dose of the toxine injected, the local action could not be obtained without producing a fever ephemeral, but of an intensity impossible to foresee, and which even in the smallest dose, even at the first injection, may cause the death of the patient.

"Even in cases where the danger does not attain such limits, the patient is always exposed to accidents grave and prolonged, particularly of the circulatory system, of the heart, the brain, and the kidneys, and to the unfortunate development of tubercular foci previously latent, and which might have remained latent had not the inoculation been practised.

"Under these conditions, I do not consider myself justified to continue an experiment of which I have accepted the full responsibility of its demonstration. But to-day my conviction is established. *I do not believe that any physician is justified in inoculating men with the extracts of the toxines of tuberculosis, and I shall not again practise the inoculations.*"

II. **Communication of M. Hallopeau.**—According to M. Hallopeau, the doses which Koch indicates for the injections are ten to twenty times too large, for in the cases of many patients he has obtained sufficient reaction with a quarter of a milligramme. It is not exact to say, as Koch has done, that patients support well the febrile access, and that as soon as it has passed they feel better than before, for those of his patients who have reacted with intensity have, for the most part, complained of painful sensations, and particularly of a profound depression, of pains in the limbs, in the sides, the epigastrium, of insomnia. In some of them these sensations have persisted for several days; they have been observed also in certain patients who have had a reaction of medium intensity. All those inoculated have become pale, and several of them have remained in a state of most pronounced anæmia. It may require a long time to establish tolerance; it is possible to experience

strong reactions after doses of the lymph smaller even than those of the first or second injections.

The liquid of Koch has not an absolutely selective action upon tubercular lesions, for the lepers inoculated in the service of M. Hallopeau had reactions of extreme violence. The phlogogenic action of the lymph is evidently exercised upon the lupous foci, but it is not circumscribed within them. In one of his patients he observed an eruption of pustules disseminated over the trunk; in others he has observed cardiac accidents, consisting in endocarditis and myocarditis; in others, abundant suppurations; in others, finally, profound and persistent anæmias.

This savant physician of the Saint-Louis Hospital concludes, with Dr. Besnier, that the dangers to which this method exposes patients, even when employed with the greatest prudence, appears to him out of all proportion to the service which it renders. At present he would not think of continuing this medication. The only cases in which the treatment of lupus by the Koch lymph would be justifiable are those affected with lupus which has proven rebellious to all other treatments, and who, with a full knowledge of the facts, voluntarily consent to run the risk of grave complications in order to obtain an amelioration of this malady.

Returning again to this subject in the last meeting of the French Society of Dermatology and Syphilography, the same author has reported a case of death occurring in his service as the result of the injections with the Koch lymph. The patient had a lymphangiectasic suppuration of tuberculous origin. He had been given five injections between the 5th of December and the 10th of January. The first was one-half milligramme, the others of one and one-half milligrammes. The general reaction had been of medium intensity, the local reaction almost nil; but after the last injection he developed a very voluminous abscess of the thigh, along the course of the dilated lymphatics. Gradually the general health was modified, and he became worse: the patient became thin, pale, adynamic, and finally succumbed after the last injection.

At the autopsy there were found at the surface and in the tissues of the lungs numerous miliary granulations, old tubercular lesions in process of regression, and a cavity of recent origin. M. Hallopeau thought that the formation of the voluminous abscess of the thigh and the crop of miliary granulations which were the cause of death were to be attributed to the injections of the lymph.

From the preceding extracts, which confirm what I said in my last letter, it is to be seen that the opinion of the therapeutic value of the Koch lymph in local tuberculosis is definitely established in France.

The inconstancy of its action, the curative effects incomplete and temporary when developed, the sharp sufferings experienced by the patients, sometimes even the most serious accidents which may result in death after a more or less prolonged delay — such appears to be the verdict of this method, according to the experiments made in our country.

I repeat what was clearly said in my previous letter, that these experiments have been instituted without the least prejudice against the method, and with the most sincere desire that it might succeed.

But if for the moment the lymph of Koch appears to us condemned from a therapeutical point of view, it is not the same from a purely experimental

standpoint. We enter with the discoveries of Pasteur and Koch in a new path, and we may be permitted to hope that in a future more or less near their researches, which must at first be purely scientific, will be rich in practical application. DR. L. BROCQ.

Selections.

Long Incubation of Chancre and Tardiness in the Appearance of Secondary Manifestations. DR. NIVET. (*Journ. des Mal. Cut. et Syph.*, No. 5, 1890.) DR. VON P. PUECH. (*Journ. des Mal. Cut. et Syph.*, Vol. II., 1890.)

On the 15th of October, 1888, a young man twenty years of age noticed a small papule upon the prepuce which was slightly pruriginous. This soon ulcerated, and a physician who was consulted toward the end of October cauterized it several times with nitrate of silver. Dr. Nivet first saw the patient early in November, when there was an ovoid ulcer the size of a ten-cent piece upon the prepuce with an indurated base. There were marked ganglionic enlargements in both groins.

Patient declared he had not had connection since the last days of August. There was thus a period of forty-five days between the moment of contagion and the appearance of the primary sore. This ulcer took a long time to heal and was not cicatrized before the 15th of December (two months).

The roseola did not appear until the 10th of January (three months from the début of the chancre). Other secondary manifestations followed, and some of them presented a certain degree of gravity.

The author thinks this observation appears to lend force to the opinion held by certain syphilographers that in winter the eruptions may be retarded.

In one of Von Puech's cases the chancre showed itself eighty-one days after the last connection, and appears to be pretty authentic. In the second of his reported cases even this long incubation was surpassed, and we find the chancre appearing ninety-seven days after the exposure. In the mean time the patient, a young servant girl, had passed through an attack of small-pox which had lasted for several weeks. The author in this case brings forward arguments in favor of the influence of febrile diseases in causing a late appearance of the chancre.

The elevated temperature, it is thought, is capable of preventing the immediate development of the syphilis microbe, though not harmful enough to cause its destruction. CHARLES W. ALLEN.

The Commencement, Duration, and Method of Treatment in Syphilis. PROF. H. LELOIR. (*Journal de Méd. de Paris*, Nov. 16th, 1890.)

As is already well known, Prof. Leloir does not administer mercury before the apparition of secondary manifestations. Mercurial preparations are, however, employed locally in treating the primary sore. As soon as the secondary signs show themselves, the author says: "I prescribe daily frictions of mercury, of which the dose varies from two to four grammes, during fifteen days. I then let the patient rest for from fifteen days to three weeks, according to the case, and thus I continue during the first ten months." Mercurial plasters are used locally for the cutaneous, and mercurial lotions for the mucous syphilides.

In rebellious cases of cutaneous syphilis, general baths containing seven grammes of the bichloride are recommended. When practicable the patient can be sent to the country or sea-shore.

After the first six to ten months inunctions are given for ten days at a time only, and an interval of three weeks to two months is allowed. This plan is continued during the second year of treatment. In exceptional cases showing persistent headache and osteocopic pains which resist the mercurial treatment, two to three grammes of potassium iodide are given, with the addition of from half a gramme to a gramme of the bromide. If after the second year the patient has been free from specific manifestations for some time, every three months a ten-days' friction course is given, and several weeks later two to three grammes of iodide of potassium in milk, at evening or after a meal. If after the beginning of the third or the fourth year the patient has been free for more than a year from all syphilitic accidents, twice a year, in the spring and fall, a ten-days' inunction cure is carried out. For a month after each of these ten-day courses the iodide is again given in two-gramme daily dose and continued for three weeks. If the patient returns after the fourth year, although free for a long time from any signs, the precaution is taken to prescribe the same semi-annual course. Neurasthenia of a severe type has been often seen to follow excessive treatment, and accompanied by dilatation of the stomach or not, as the case may be. The author has known it to be regarded as cerebral or cerebro-spinal syphilis, and the excessive treatment which has caused the condition to be persisted in. The author admits that he has himself more than once fallen into the error of mistaking a neurasthenia from the abuse of treatment for cerebral syphilis. In expiation of the fault he has many times caused patients in spite of themselves to give up specific treatment prescribed for them for supposed cerebral syphilis.

Mercurial preparations are given by the mouth only when it is impossible to do otherwise, since they are more likely to occasion neurasthenia when given internally. Eruptions in delicate skins from inunction can usually be avoided by using only a freshly-prepared ointment made with fresh benzoated lard: having the parts washed carefully twelve hours after the frictions, and some lotion or powder applied. CHARLES W. ALLEN.

Malleus Humidus. DR. LUKASCHEWITSCH reports two cases at a meeting of the Society of Physicians of Kiew. (*Monatsh. f. prak. Dermat.*, Bd. XII., No. 2.)

(1.) A Jew, 16 years old, in whom the disease had existed for five months under the form of tubercular lesions in the skin, the muscles, and mucous membranes, developed a large ulcer on the hard palate, with muco-purulent discharge from the nose. The case was interesting owing to the favorable influence exerted on the disease by warm salt baths. It led to the absorption of many infiltrations.

(2.) A Cossack, aged 25, was infected from a horse two and a half months before he was seen in May, 1890. Two large infiltrated masses of the size of a goose-egg were present, one on the right and one on the left thigh. The inguinal glands were also enlarged. Inunctions of mercury and iodide of potash internally produced no effect. Injections hypodermically of hydrarg. bichlor. (1 : 2,000) caused the newer infiltration to disappear altogether and the older one to diminish one-half in size. In August he was given tinct. iodine 2–7 drops. New lesions, however, developed; loss of

strength set in accompanied by severe diarrhœa. When the case was reported the patient was a little better, but there was little hope of recovery.

In both cases, the diagnosis was confirmed by the microscope, by cultures and inoculations on cats and guinea pigs.

Dr. L. also briefly refers to the cases of malleus reported in Russia during the last ten or eleven years. They are 46 in number (45 men, 1 woman), and of these only five ran a chronic course. Inoculation occurred three times from man to man and twice from the corpse. The infection took place through the various mucous membranes or by accidental wounds, or through the air, the bacilli in a dry state retaining their vitality for three months. When the disease was inoculated the period of incubation was from three to six days, but it was unknown when infection occurred in other ways. The diagnosis was rendered very difficult before the appearance of cutaneous lesions or implication of the mucous membranes, for the reason that examination of the blood in acute cases is frequently, in chronic ones constantly, negative in demonstrating the presence of the bacilli. Of the 46 cases, only 3 acute and 2 chronic ones remained alive. Therapy, warm baths, and iodide of potash in large doses. GEORGE T. ELLIOT.

Primary Tuberculosis Cutis by Inoculation. W. DUBREUILH and B. AUCHÉ. (*Archives de Méd. Expérim.*, II., 1890, p. 601.)

A robust young woman, 23 years of age, is in attendance on a consumptive, one part of her duties consisting in washing the patient's linen—notably the handkerchiefs containing tubercular sputum. Shortly after the death of the consumptive she noticed a little nodular swelling, accompanied by redness and pain on pressure, over the interphalangeal joints of the last two fingers of the right hand. A little thin sero-pus could be squeezed from the nodule. A few days later one of the axillary glands became painful, swollen, and opening spontaneously, discharged considerable pus, a fistulous track remaining. In the course of the next few weeks a number of little tumors developed on the forearm, arm, and shoulder, many of them breaking down and discharging thin pus. The primary lesions over the knuckles in the meanwhile assumed a warty appearance. The microscopic examination of the warty growths showed an irregularly thickened, horny layer, a markedly hypertrophic rete, and an intense infiltration in the papillary layer and cutis, with giant cells in considerable number. Tubercle bacilli were present in the sections in the usual scanty number; they were more abundant in the pus from the axillary gland and the nodules on the arm. Inoculations on Guinea-pigs gave positive results. S. POLLITZER.

On Ichthyol Varnishes. UNNA. (*Monatshefte f. prak. Dermat.*, Bd. XII., No. 20.)

Unna undertook experiments with various substances in order to obtain an ichthyol varnish which was soluble in water and which would offer the advantages and none of the disadvantages of other ichthyol preparations. He recommends the following as the best:

℞ Ichthyol, ...	40 parts.
Starch, ...	40 "
Sol. of albumin, ...	ca. 1–1½ "

The starch is to be evenly mixed with the water, then the ichthyol is to be well rubbed up in it, and lastly the albumin is to be added.

He also advises another varnish containing carbolic acid, but as this latter would precipitate the albumin, the formula is a little different :

℞ Ichthyol,	25 parts.
Carbolic acid,	2½ "
Starch,	50 "
Water,	22½ "
Aq.,	ad 100 "

The ichthyol and carbolic acid are to be dissolved in the water by means of heat and the starch is then added to the solution.

Both of these varnishes dry rapidly and completely, do not dissolve under the influence of sweating, and can be easily washed off. They are applicable for the treatment of various circumscribed cutaneous diseases, and are recommended for acne, rosacea seborrhoica, rosacea simplex after frost-bite, and especially in lupus erythematosus. Also in certain forms of eczema, in intertrigo, in his tubercular eczema [a large pustular eczema occurring especially about the natural openings of the face, associated with tubercular glands and occurring in children, generally described as of a strumous type—ELLIOT], and again in erysipelas.

To the ichthyol varnish chrysarobin (2 to 5 per cent) can be added, or pyrogallol, resorcin, sulphur, etc., and consequently it becomes useful in the treatment of all parasitic eczemas, of psoriasis, or of other cutaneous diseases presenting circumscribed lesions and patches. He suggests that when a new drug is added to the varnish an equal amount of water or of some oil, preferably linseed oil, should likewise be mixed with it, so as to facilitate its incorporation and to preserve the thick-fluid consistency of the preparation. GEORGE T. ELLIOT.

Epidemic Zoster. EMIL WEIS. (*Archiv f. Dermat. u. Syph.*, XXII., 1890, 609.)

Pfeiffer's analysis of 117 cases of zoster led him to the conclusion that the lesions in this affection follow the cutaneous blood-vessels and not the nerves. Weis, while accepting the infectious character of the disease, opposes Pfeiffer's theory of the distribution of its lesions. He bases his argument on the distribution of the lesions in some cases which he narrates, in which the region affected by the zoster was supplied from two wholly distinct vascular sources, though by only one nerve. The occurrence of points of tenderness along the course of the nerve also indicate a nerve implication. S. POLLITZER.

Book Reviews.

WOOD'S MEDICAL AND SURGICAL MONOGRAPHS. Vol. VIII., Nos. 2 and 3; Vol. IX., Nos. 1, 2, and 3. Wm. Wood & Co., 56 Lafayette Place.

A glance at the table of contents of these several numbers indicates the great variety and practical value of the books and monographs selected for reproduction.

November No., 1890: Treatment of Uterine Affections by Massage, by Dr. Ernst Arendt; Cosmetics—A Treatise for Physicians, by Dr. Heinrich Paschkis; Affections of the Stomach in Diseases of the Male Genital Organs, by Dr. Alexander Peyer.

December No., 1890: Practical Guide to the Demonstration of Bacteria in Animal Tissues, by Dr. H. Kühne; On the Present Position of Antiseptic Surgery, by Sir Joseph Lister, F.R.S.; Cancer and its Complications, by

Chas. E. Jennings; The Treatment of Epilepsy, by Dr. Chas. Féré; Handbook to Dr. Koch's Treatment in Tubercular Disease, by Drs. Chas. Grun and Severn.

January No., 1891: Advances in Bacteriology, by R. Koch, M.D.; Formulary of New Remedies and New Medicinal Preparations, by Dr. Bocquillon-Limousin: Anæsthetics—A Discussion by Dr. Wm. McEwen and others.

February No., 1891: The Clinical Uses of Prisms and the Decentring of Lenses, by Ernest E. Maddox, M.D.; Electricity in the Treatment of Uterine Tumors, by Dr. Thos. Keith, M.D., LL.D., and Skene Keith, F.R.S.; Ether Drinking: Its Prevalence and Results, by Ernest Hart.

March No., 1891: The Modern Diagnosis of Diseases of the Stomach, by J. M. Purser, M.D., Dublin; Unsoundness of Mind in its Legal and Medical Considerations, by J. W. Hume Williams, London; Baldness and Grayness: their Etiology, Pathology, and Treatment, by Tom Robinson, M.D., London.

Want of space forbids a detailed examination of these numerous monographs, but the well-known reputation and ability of the authors constitute a sufficient guarantee of the excellence of their work. The low price of this periodical publication places the best foreign medical literature within the reach of all.

Books and Journals Received.

Un Cas de Lèpre Systematisée Nerveuse avec Troubles Sensitifs se Rapprochant de ceux de la Syringomyélie, par M. le Dr. Georges Thibierge.

Le Traitement du Lupus vulgaire par les Injections de Lymphe du Koch, par le Dr. Georges Thibierge.

Note sur les Resultats Actuels du Traitement du Lupus par la Méthode de Koch, par le Dr. Georges Thibierge, Médecin du Bureau Central, Paris.

La Méthode de Koch au point de Vue Dermatologique (2d article), par le Dr. Georges Thibierge.

De la Cachexie Pachydermique, ou Myxœdème, par le Dr. Georges Thibierge.

Les Altérations Cutanées de la Syringomyélie, par le Dr. Georges Thibierge, Médecin des Hôpitaux, Paris.

Anatomie Pathologique de l'Eczéma—Première Partie, Eczéma Aigu; Deuxième Partie, Eczéma Chronique, par le Professeur H. Leloir.

Troubles Urinaires Premonitoires des Myélites Syphilitiques, par Henri-Marie-François-Joseph Sénéchal. Thèse de Doctorat, Lille, France.

De l'Emploi du Menthol dans les Affections Prurigineuses de la Peau, par les Docteurs W. Dubreuilh et P. Archambault.

Cystocèle Inguinale, Diagnostic et Traitement (Cure Radicale), par le Dr. Octave Guelliot.

Sur la Sterilisation des Instruments en Gomme, par le Dr. Heinrich Alapay.

Ueber Inoculationslupus, von Dr. J. Jadassohn, Breslau.

Schäden bei Behandlung der Gonorrhöe des Mannes, von Profes. Eduard Lang, Primärarzt in Wien.

Einschränkungen beim Gebrauch des Quecksilbers in der Syphilistherapie, von Prof. Eduard Lang.

Prof. Kaposi's Mittheilungen über einen letal verlaufenen Fall nach Oleum cinereum-Injectionen, von Prof. Eduard Lang.

Beitrag zur Kenntniss der tertiär-syphilitischen Affectionen des Penis, von Dr. A. F. Buechler, New York.

Neuere Daten zur Lehre von den Urethralstricturen, von Dr. Heinrich Alapay.

Klinisch-Experimentelle Studien über Chirurgische Infectionskrankheiten, von Dr. J. Fessler.

Pemphigus Vegetans (Neumann) Illustrated by H. Radcliffe Crocker, M.D., London.

Paget's Disease Affecting the Scrotum and Penis, Illustrated by beautiful chromo-lithographic plate and lithograph of microscopic drawings, by H. Radcliffe Crocker, M.D., London.
The Treatment of Eczema in Elderly People, by L. Duncan Bulkley, M.D.
Acute Circumscribed Cutaneous Œdema, by M. B. Hartzell, M.D.
A Peculiar Case of Addison's Disease, by A. H. Ohmann Dumesnil, M.D.
An Unusual Case of Atrophy of the Skin, by A. H. Ohmann Dumesnil, M.D.
Case of Ringworm of the Scalp Complicated by Pustular Eczema—Cure, by A. H. Ohmann Dumesnil, M.D.
Cases of Successful Operation for Bulbo-membranous close Stricture by Internal Urethrotomy, by E. R. Palmer, M.D., Louisville.
The Initial Lesion, by E. R. Palmer, M.D.
Circumcision, by E. R. Palmer, M.D.
Paranephric Cysts, by Robert Abbe, M.D.
Anodal Diffusion as a Therapeutic Agent, by Frederic Peterson, M.D.
Syphilis of the Nervous System, by E. R. Fisher, M.D.
Chronic Urethritis, by L. Bolton Bangs, M.D.
Purpura Hemorrhagica, by George R. Lockwood, M.D.
Psorospermosis Follicularis Cutis, by L. Duncan Bulkley, M.D.
A Case of Hutchinson's Varicella Prurigo, by Herman Goldenberg, M.D.
Some Points in the Treatment of Gonorrhœa, by Gardner W. Allen, M.D.
Some Observations on Stricture of the Male Urethra, by R. W. Stewart, M.D.
Koch's Treatment of Tuberculosis, by Harold C. Ernst, M.D.
Stricture followed by Rupture of the Urethra and Extravasation of Urine, External Urethrotomy, Recovery, by J. Blake White, M.D.
Case of Painful Subcutaneous Neuroma (Neuro-Fibroma), by J. A. Cantrell, M.D.
Dangers arising from Syphilis in the Practice of Dentistry, by L. Duncan Bulkley, M.D.
Case of Cystitis, with the Formation of a thick Epidermal Sheet in the Bladder—Pachydermia Vesicæ, by A. T. Cabot, M.D.
Some Observations on Kakké, the National Disease of Japan, by Albert S. Ashmead, M.D.
A Problem in Sociology, by E. R. Palmer, M.D.
Micro-Organisms of Leprosy, by Dr. P. G. Unna.
Vorlesungen über Allgemeine Pathologie der Haut, von P. G. Unna.
Über "Ichthyolfirnisse," von P. G. Unna.
Über die Insensible Perspiration der Haut, von P. G. Unna.
Natur und Behandlung des Eczems, von P. G. Unna.
Zur Methodik der Untersuchung des Elektrischen Leitungswiderstandes der Haut, von Dr. Siegmund Lewith.
Mittheilungen über Versuche mit der Koch'schen Injectionsflüssigkeit" bei Lepra und Lupus Erythematodes von Dr. Ed. Arning, Hamburg.
Ueber die Ambulante Behandlung der Epididymitis mittels eines neuen Compressionsverbandes, von Dr. Ed. Arning, Hamburg.
Ueber Epidemischen Zoster, von Dr. Emil Weis.
Untersuchungen über Favus, von Prof. Dr. F. J. Pick in Prag.
Zur Kenntniss der Acne Frontalis seu Varioliformis (Hebra), Acne Frontalis Necrotica (Boeck) von Prof. F. J. Pick.
Zur Electiven Wirkung des Koch'schen Mittels mit Krankendemonstration, von Prof. F. J. Pick.
Vorläufige Mittheilungen über die Versuche mit dem Koch'schen Mittel an der K. K. Dermatologischen Klinik in Prag, von Prof. F. J. Pick.
Ueber einen Blutbefund bei Purpura Hæmorrhagica, von Dr. Theodor Spietscha. (Illustrated.)
Ueber den Elektrischen Leitungswiderstand der Haut bei Sklerodermia, von Dr. Siegmund Lewith. (Illustrated.)
Varios Casos de Sifilis y de Algunas Anomalias Anatomicas del Apparato Genital de la Mujer, por el Dr. D. Juan Soler y Buscalla.
Du Prurigo Hivernal, par le William Dubreuilh, Bordeaux.
Atypic Herpes Zoster Gangrenosa, with report of two cases, by Merrill Rickets, M.D.
Notes on the Examination for Tubercle Bacilli, by Ludwig Weiss, M.D.
The Parasitic Nature of Psoriasis: Its Treatment by Mercury, by E. D. Mapother, M.D., F.R.C.S., etc.

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Original Communications.

CASES OF LESIONS OF THE GENITALS, FEMALE AND MALE.[1]

BY R. W. TAYLOR, M.D.

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THE following cases are thought worthy of presentation in our clinical session:

CASE I.—M. S., aged 30, German domestic, entered Charity Hospital November 8, 1890, for severe vulvar lesions. A careful study of her case from the date of her first entry into Charity Hospital in February, 1883, has convinced me that she has not suffered from syphilis, nor has she had chancroids at any time. In 1882 she was kicked in the privates, and as a result much swelling and inflammation supervened. These symptoms were alleviated at the hospital, but on her departure the vulvo-anal region was still somewhat swollen and red. From that time on she led an irregular life, suffered from leucorrhœa, and was careless of her person. As a result, chronic inflammation attacked the external genitals and eventuated in the conditions found at the date of her last admission. Examination revealed the following facts: The whole vulva and the anal region were the seat of marked hyperplasia; the left labium minus was greatly enlarged; the prepuce of the clitoris much increased in size, while the right labium minus was hypertrophied and fringed on its free margin. Fleshy tabs of small and large size jutted from the lower part of the vulva, probably from the fringe of membrane forming the fourchette. Much hyperplasia existed in the vulva itself, extending from the tumors just described. The perineum was much thickened and hypertrophied, and around the anus hyperplastic tabs and small pedun-

[1] Read in the Section on Genito-Urinary Surgery of the N. Y. Academy of Medicine, Feb. 12, 1891.

culated, fleshy tumors or hemorrhoids were to be seen. The anal orifice was hard and fibroid, and an inch and a half above it an annular stricture of the rectum of considerable density, but yet rather dilatable, was felt. The lower part of rectum was hard, infiltrated, excoriated,

FIG. 1.

and rough. The recto-vaginal septum was thickened and hard, and a recto-vaginal fistula was found just above the fourchette. The woman had long suffered from incontinence both of urine and fæces. The appearances of the external genitals are well shown in the colored drawing, and the hypertrophied parts I now present for inspection,

they having been removed by my house surgeon, Dr. Newmann. Inspection of the hypertrophied labia shows that a deep cut had been made by the injury of ten years ago well into the substance of the left labium minus.

This case is particularly interesting in its origin and course. Following a contusion, hyperplasia of the vulva was developed, which, not being properly treated, has gone on and ended in grave conditions which seriously impair the well-beeing of the patient and will, in all probability, sooner or later lead to a fatal issue. Cases hitherto reported of vulvar hyperplasia and hypertrophy have generally had their origin in some local lesion or benign new growth which had been subjected to continued irritation. In this case a lacerated and contused wound was the starting-point of an irritation which went on for years and has produced the most serious consequences. Not only is the whole vulva and lower part of the vagina involved, but the hyperplastic process has invaded the recto-vaginal septum, the whole circumference of the rectum as high up as four inches, at least, producing a rather close stricture and the perineum and anal region are also hypertrophied and distorted. The recto-vaginal fistula is but a sequela of the inflammation of the tissues concerned and of the rectal stricture. In my experience it is rather rare to see so much involvement of the anus and rectum and recto-vaginal septum result from simple hyperplasia of the vulva. It is very common to see this complicating condition of a simple nature in old syphilitics linger after the cessation of the diathesis, and in them the infiltration of the vagina, rectum, and anal region is quite common. Therefore when questioning this woman and examining the old records of the hospital concerning her case, I expected to find a distinct syphilitic history, but in this I have failed after taking due pains. Carelessness, want of cleanliness, vaginal discharges, and the alcoholic habit have undoubtedly much to do with this woman's present condition.

This case, therefore, carries with it this very important lesson: that trauma of the vulva should be promptly and carefully treated until all evidence of hyperæmia and infiltration of the parts has disappeared. It clearly shows that vulvar hyperplasia extends to the rectum and anus, and there produces changes which may lay the foundation for invalidism and in the end lead to death (see Fig. 1).

The next case is of especial interest as showing the extent to which indurating œdema may be developed in the vulva of a woman in the early stages of syphilis. It is not uncommon to see well-marked instances of vulvar hypertrophy, due to hard œdema complicating hard chancres and various secondary lesions, also to occur in persons in an active stage of syphilis as a result of traumatism; but it is very rare

indeed to see the morbid process produce such an elephantine growth as is shown by this case.

For the details and the photograph of it I am indebted to the courtesy of Dr. J. Chas. Graham, of Columbus, Ohio.

FIG. 2.

CASE II.—The patient, a prostitute, aged 18, contracted syphilis in July, 1888, having a chancre, sore throat, roseolous syphilide, and other manifestations. The labia majora were then slightly enlarged and somewhat indurated. She underwent a short course of treatment with no special local medication. Rather more than a year after infec-

tion she was seen by Dr. Graham, who recognized upon her body a variety of syphilitic manifestations. At this time, however, the most noticeable feature of the case was the tumor, which is shown in the photograph (see Fig. 2). This shows the external genitals and the appearances strike one as those of a woman from whose vulva the head of a child is just pushing out. The size and shape of the tumor are clearly defined. It was of a pale red color, and roughened from marked enlargement of the papillæ. The upper part of the tumor was perfectly round and was composed of the infiltrated soft parts of the vulva, while below a cleft can be seen which admitted a probe nearly to the vagina. On the lower part of the tumor the hypertrophied labia majora may be seen, looking like two sausages placed in V-shape, between the arms of which the tumor rested. The tissue was hard and almost cartilaginous, and pressure scarcely had any effect on it. Its surface was dry, except between the duplicatures and sulci, but nowhere were there excoriations or ulcerations. The mass was removed by Dr. Graham and weighed four and one-half pounds. The induration of the labia majora was very persistent and rebellious to treatment.

Equally remarkable with the size of the tumor was the rapidity of its growth, since a little more than a year had elapsed from the date of the onset of the indurating œdema complicating the hard chancre to the full development of the tumor (see Fig. 2).

It is well known that epithelioma of the penis generally begins at its distal extremity, more commonly on the prepuce, and rather exceptionally upon the glans. It has been observed to begin upon the scrotum, and by extension to invade the penis.

The following case is of interest as showing a well-marked epithelioma seated on the cutaneous sheath of the penis, midway between the meatus and the pubis.

Case III.—A healthy Frenchman, aged 25, entered Charity Hospital April 24, 1890. He had had no venereal disease, but ten months previously had noticed a swelling on the side of the penis as large as a pea. This lesion enlarged, gave issue to some pus, and was picked by the patient with a pin and also burned with various caustics. The result of all this bad treatment was an elevated and exulcerated new growth, which extended fully half-way around the organ at its middle portion. Patient thought that it reached its present size by rapid growth five months previously, and that it had since remained stationary. This ulcer is well shown in the colored drawing here shown. Its surface was uneven, with here and there the semblance of granulations, and in its centre a greenish-brown pellicle. Scattered over the more external area were a number of pale, flabby-looking elevations, which were evidently composed of hypertrophied epithelial tissues. The margin of the new growth was firm, sharply defined, and even steep, and of a markedly festooned outline. That portion of the

margin nearest the glans penis was of pearly white color, hard and firm, and felt like some epitheliomas which are found on the face. Toward the middle of the new growth palpation showed that the corpus cavernosum and corpus spongiosum were involved, and that total oblation of the organ was necessary. This the patient refused to submit to, and he left the hospital.

In addition to the peculiar site of the tumor, the case is interesting as showing the development of epithelioma in a young man of 25 years, very probably as the result of injurious irritation of a simple inflammatory growth.

In ninety-eight cases Demarquay observed epithelioma of the penis nine times between the age of twenty-one and thirty, while the statistics of Kaufmann (including 130 cases) show the onset of this terrible disease in five in the period included between those ages. Epithelioma of the penis is, therefore, comparatively rare in men under thirty years of age.

PSEUDO-PIGMENTARY LESIONS ON THE HANDS OF MILLERS.

By GEORGE T. ELLIOT, M.D.,
Assistant Physician to the New York Skin and Cancer Hospital.

A. B., male, aged 38 applied for treatment at the Out-door Department of the New York Skin and Cancer Hospital in January, 1891, presenting the evidences of a papular syphilide on the right palm. He could not or would not give any history of infection, denied any and all previous outbreaks of the disease, and claimed that he had always been perfectly healthy and well. The patient stated in regard to his occupation, that he was a miller, but had been out of employment for some six months. While examining the eruption on his hand, it was noticed that on its dorsum, as well as on that of the fingers, there were distributed without any particular arrangement numerous dark spots, and the same condition was noted on the left hand. These lesions were of variable size and configuration, some larger than a good-sized pea, the majority somewhat smaller. They ranged in color from a brown to a grayish metallic black and some were almost black. They were not elevated above the level of the skin; no apparent change in the skin itself could be detected; the horny epidermis covering was perfectly normal.

When the patient was questioned in regard to the origin of these spots, he affirmed that they were not the result of any previous eruption, but were consequent upon his trade. He also said, that all the men engaged in the same kind of work presented precisely similar

symptoms, and that the discolored spots served as a sort of badge indicative of the special work they were accustomed to do. It appeared that this latter consisted in smoothing off every day all inequalities and roughnesses, which had formed upon the nether stone during the process of grinding the wheat into flour. For that purpose, the hardest kind of steel chisels were used, but the hardness of the stone was such that small pieces and minute particles of the steel would be continually chipped off. It was to the penetration of these into and their becoming imbedded in the skin that the patient attributed the discolorations seen on his hands. He also stated that when the particles of steel were very small, there would not be any perceptible wound at the point of entrance, though such would be the case if the piece was large. Still, healing took place immediately, and there had been at no time any suppuration or inflammatory change in the skin. The presence of the steel produced no discomfort whatever unless the piece was a large one, and he pointed out a place on the right middle finger, which troubled him somewhat, where a hard body of some size could be felt imbedded in the subcutaneous tissue.

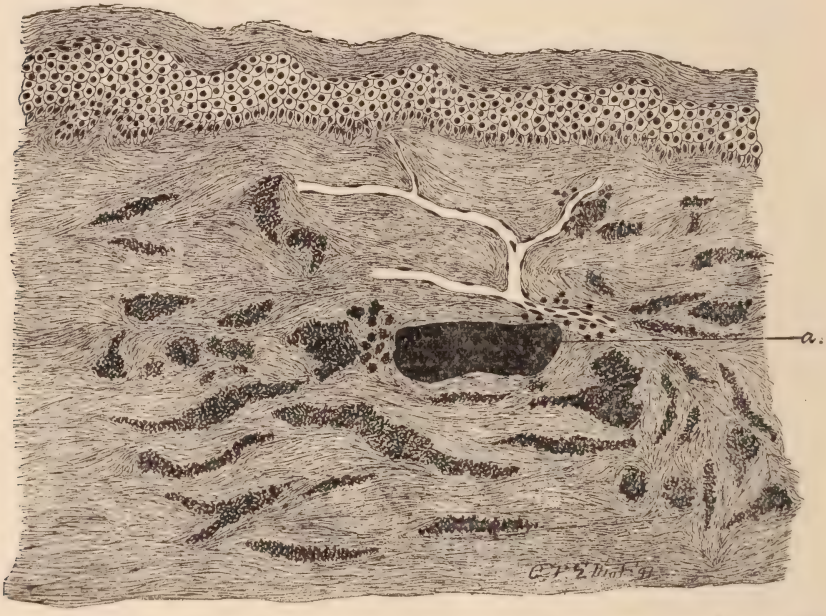
The patient allowing a specimen to be excised for microscopic examination, a couple of the spots were removed from the dorsum of the right middle finger. The point, which it was mentioned troubled him somewhat, was also incised, and from below the skin a plate of steel $\frac{1}{8}$ inch long and $\frac{1}{12}$ inch broad was removed.

The specimen excised was hardened in alcohol, cut with the microtome, and the sections were stained with hæmatoxylon.

The horny layer of the epidermis was found much thicker than usual for the dorsum of the finger. The rete Malpighii was normal, no change of any consequence being observed. In the cutis, below the areas which to the eye had appeared pigmented, small particles of steel were seen, one or two or more of them in a section, lying most frequently about the middle of the cutis, sometimes somewhat higher up. They appeared to be simply imbedded in the tissue, no distinct encysting wall being observed around them, and they did not appear to produce any particular irritation, inasmuch as about the blood-vessels in their vicinity there were only a very few infiltration cells. In addition to the original steel particles, however, there were also many small clumps and scales, irregular or angular in shape, of a light or dark brown color, distributed throughout the cutis, while larger masses and elongated bands, some uniform, others with branching prolongations, occupied the lymph spaces. For the most part these bands ran parallel to the level of the skin, but many lay obliquely and also perpendicular to it. They appeared to be composed of coarse and fine granules aggregated together. The smaller clumps of gran-

ules were situated more especially in the upper part of the cutis, while the larger masses and bands were around and about and below the steel particles.

The entire depth of the corium was thus occupied by these granular aggregations; some had also penetrated and been formed even in the subcutaneous fatty layer, while here and there a portion of a coil of a coiled gland was found, impregnated with the same brown color as was shown by the granules, and likewise traces of them were seen in some of the lymphatic vessels, or small clumps were observed in the immediate vicinity of a blood-vessel. From the microscopical examination, it is, therefore, evident that these apparently pigmented



spots were not true pigmentations, but only discolorations due partly to the presence in the cutis of the minute steel particle, and partly to the granular masses situated in the lymph spaces formed by the interlacing fibre bundles. Of course, the greater part of the discoloration owed its existence to the latter, as may easily be judged from their abundance and wide distribution, and it is consequently interesting to trace out the source and manner of formation of these granular masses. Obviously, they were the result of the action of the oxygen in the blood and tissues upon the steel particle, which caused the oxide of iron to be formed. These rust granules being loosely coherent and detachable, we may safely presume that they were swept along by the lymph currents, until they became lodged in some one

or other of the tissue spaces in which they were found. Here they would be joined by others carried along in the same way, the aggregations would become larger, their presence more perceptible, and in proportion as their size and number increased, so would the discoloration become objectively more distinct and extended. Such a course would be in conformity with the clinical facts obtained from the patient, who stated that a spot scarcely perceptible at first would become little by little more apparent and larger. Besides, no other explanation can be given for the presence of the rust granules at a distance from the particle of steel, nor is there any other way in which a speck of iron, $\frac{1}{16}$ to $\frac{1}{20}$ of an inch in its longest diameter, could have evolved a discoloration $\frac{1}{8}$ to $\frac{1}{4}$ of an inch in breadth, as was the case in one of the spots excised.

Still, it cannot be supposed that the growth in size of these spots would be without limit. That would be contrary to the clinical aspects of the case, as none of the discolorations were larger than $\frac{1}{4}$ inch in diameter and many were much smaller, and that notwithstanding that they had existed for a long time. Moreover, the patient had been engaged in the same kind of work for years, and yet there were only twenty-five to thirty of the discolorations on each hand, and he stated unhesitatingly that they were now, after six months' idleness, much fewer in number than they had been when he had worked. It is scarcely possible that during many years only so small number of steel particles had penetrated into the skin, and when this is taken in conjunction with the observation he had made, that the discolorations diminished in number when he was idle, the presumption arises that elimination of the rust granules from the lymph spaces must also take place. The granular masses not being encysted, but lying in the lymph spaces between the fibre bundles, they would certainly be still subject to the lymph currents, and if these originally swept the granules into the situation in which they were found, there is no reason whatever for their not carrying them gradually farther and farther until they became lost in the general circulation. Besides, the presence of the rust granules in the lowest layers of the cutis, in the subcutaneous tissue, in the lymphatic vessels, and in the vicinity of the larger blood-vessels, all at a distance from their source—the speck of steel—testify strongly in favor of the belief that an eliminative course was pursued in regard to these granular masses. From the clinical and microscopical facts presented by this case, it would therefore seem probable that the steel particle penetrating into the cutis and becoming oxidized, the supply of the granules predominating at first over their elimination, an increase in size of a spot occurred, but when the supply diminished, an equilibrium became established and the discoloration

remained stationary for a time, until, the elimination predominating, gradual diminution in size followed. When, however, the supply ceased entirely, the speck of steel having been completely oxidized and disintegrated, then the eliminative process would gradually cause complete disappearance of the discoloration. The theory of the origin, growth, and disappearance of the spots just given agrees so accurately with the clinical course pursued, as shown by the period of growth of the spot, the one during which it remained stationary, and the one in which decrease in size occurred and finally total disappearance ensued, that it appears justifiable to conclude that it offers a reasonable explanation for the existence and life history of the discolorations. The results obtained from the study of this case are certainly not of any practical utility, but yet it serves as an illustration of pseudo-pigmentation resulting from a man's trade, and for that reason it should be included in the same class which contains workers in silver, the discoloration of whose hands has been so admirably described by Lewin.[1]

7 WEST 31ST STREET.

REPORT OF A CASE OF VESICAL AND PROSTATIC CALCULI, FORMED UPON NUCLEI OF BONE AS THE RESULT OF NECROSIS OF THE PELVIS AND PERFORATION OF THE BLADDER.[2]

BY SAMUEL ALEXANDER, A.M., M.D.,

Professor of Genito-Urinary Surgery, etc., in the Bellevue Hospital Medical College; Surgeon to Bellevue Hospital.

ON August 20th, 1889, James C., aged 22 years, was admitted to Bellevue Hospital, suffering from partial retention of the urine. He stated that he had been operated upon for vesical calculus just a year before by Dr. J. S. Gouley, that a large stone had been removed through the perineum, and that after remaining in the hospital for nine weeks he had been discharged "cured."

He said that he had had no further trouble until four weeks before his admission, when he was suddenly seized with a severe pain in the bladder. This pain came on at night after having driven in a wagon over the pavements during the afternoon. On his attempting to urinate the pain was increased, and the effort was accompanied by a severe spasm of the bladder; the urine could only be forced out in drops, and was bloody. These symptoms continued until his admission to the hospital, although at times he was able to pass his urine in

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[1] "De l'argyrie locale des ouvriers en argenterie." G. Lewin. Ann. de Dermat. et de Syph., Nos. 8, 9, 1887.

[2] Read before the Genito-Urinary Section of the New York Academy of Medicine.

a dribbling stream, but the act was always accompanied by great pain in the bladder and perineum and at the end of the penis, and by the passage of blood.

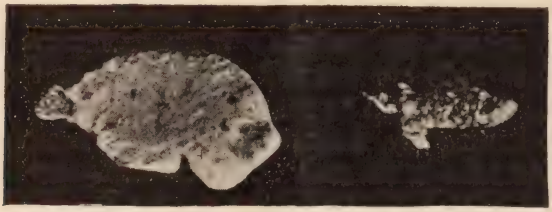
I saw the patient immediately after his admission to the hospital and made an examination. Suspecting the existence of calculus, I attempted to introduce a Thompson's searcher into the bladder; the instrument was arrested in the prostatic portion of the urethra. I put my finger into the bowel to ascertain the cause of this obstruction, and discovered that the right lobe of the prostate was seemingly increased in size and was exceedingly hard. After a little manipulation the searcher entered the bladder, and as it passed through the prostate I detected a calculus which seemed to occupy its right lobe. Owing to the nervous and exhausted condition of the patient and the pain which any manipulation of the instrument caused in the bladder, I did not make any further examination at this time, but simply emptied his bladder and ordered an anodyne. When examining the patient I noticed that his right hip was stiff and that he walked with a limp, but as he did not complain no notice was taken of it.

On the following day, August 21st, 1889, I performed the median operation before the house staff. On introducing my finger into the prostatic urethra I discovered a calculus (see Fig. 1) which occupied the prostatic urethra and which was partially encysted in its right lobe and extended backward into the bladder. This I easily dislodged and extracted with forceps. I then examined the bladder and discovered a much smaller calculus (see Fig. 2) attached to the right wall of the bladder near the internal urethral orifice. This I detached with my fingers and then removed it. The bladder was washed, a perineal tube inserted, and the patient put to bed. He made a rapid and satisfactory recovery, and left the hospital in about three weeks.

Shortly after the patient left the hospital, I discovered that the calculi which I had removed were formed upon nuclei of bone. In fact, they consisted of bony spiculæ covered by a thin phosphatic deposit. I was at first unable to account for this fact, but upon consulting the hospital records I learned that the calculus which Dr. Gouley had removed in 1888 was likewise formed upon a nucleus of bone, and that as early as 1883 the patient had been treated in the hospital for "an obscure affection of the hip and for abscess of the thigh." The following facts are from the history taken at that time: "The patient was admitted to the First Surgical Division, Ward IV., on May 9th, 1883. He had been suffering for sixteen months previous to this time from pain in the region of the right hip-joint. He said that without any assignable cause the joint gradually became stiff and painful, especially upon motion. One week before his admission to

the hospital he noticed a swelling on the upper and outer aspect of the thigh, and as this increased he was unable to walk without great pain. He therefore applied to the hospital for relief. On his admission he was examined, and a large swelling was found just below and behind the right trochanter; the skin covering this was red and hot. The hip-joint was immovable, and an attempt to flex it caused the pelvis to tilt upward.

The right thigh was one inch greater in circumference than the left. Deep-seated fluctuation was found over the swelling. It was incised and a large quantity of pus was evacuated. "The abscess did not extend to nor communicate with the joint." No mention is made of the cause of this trouble in the history. The abscess was drained and the patient was discharged as cured in July, 1883. He at no



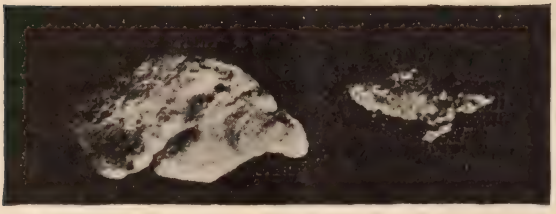


FIG. 1. FIG. 2.

time during his stay in the hospital complained of any bladder symptoms.

On July 25th, 1888, he was again admitted to the hospital, into the service of Dr. J. S. Gouley, to whose courtesy I am indebted for the following facts of the history and also for the specimens which accompany them. After his discharge from the hospital in 1883 he remained well, except for some stiffness of the right hip, for three years. About eighteen months ago (January, 1887) he began to have pain in the region of the bladder and a frequent desire to urinate, with some pain at the end of the act. The flow of urine would sometimes be followed by a few drops of blood. These symptoms, he says, appeared suddenly and lasted for ten days. For some time after this

he felt well except for pain in the bladder, which recurred at irregular intervals, but especially after any exertion. He then began to have a more frequent desire to urinate, his pains increased in severity, and he was obliged to give up all work. Rest in bed caused the pain to disappear, but any movement caused it to return. The urine during this period was usually bloody. On his admission to the hospital, August, 1888, Dr. Gouley examined him and found a large stone in the bladder, which he removed by a perineal lithotrity on August 1st, 1888: 350 grains of detritus were evacuated, and there were also four pieces of bone upon which the calculus matter was deposited.[1] Dr. Gouley tells me that this was but a single calculus, and that all the four fragments of bone were imbedded in it. The patient made a rapid recovery and was discharged September 3d, 1888, and he made no complaint of trouble in his hip during this time, "although it was tsiff and he limped when walking."

One year later, August, 1889, I operated, with the result already stated.

On December 7th, 1889, four months after my operation, the patient returned to the hospital and was admitted to Dr. Gouley's wards. He stated that about six weeks before he began to have during the act of micturition a sharp pain in the region of his right hip. This continued for several weeks and then disappeared, but the hip continued to be painful and tender, and just before entering the hospital it began to swell. Examination showed that there was a swelling over the right hip, more marked below and back of the great trochanter. This swelling gradually increased in size. On January 25th, six weeks after admission, the skin over it being red and fluctuation being detected, an incision was made an inch and a half below the gluteal fold, a little to the outer side of the median line of the thigh. "About 3 iv. of a dark purulent fluid, having an almost feculent odor, was evacuated." Examination of this fluid showed that it contained urea.

The bladder was injected with a solution of borax and this solution came out through the wound over the hip. A catheter was introduced into the bladder and the abscess cavity was then injected. The solution escaped through the catheter.

The abscess cavity was drained and the bladder washed daily; the urine has since then escaped in part through the wound and in part through the urethra.

In August, 1890, the patient began to complain of pain in the

[1] This specimen and another calculus removed from the patient by Dr. Gouley were presented.

bladder and a frequent desire to urinate. An examination by Dr. Gouley showed the presence of a small calculus. Owing to the poor condition of the patient an operation was deferred, and the patient was given a tonic and stimulating course of treatment, with rest.

In October, 1890, an examination of the rectum was made and revealed a prominent roughened piece of bone on the inner surface of the ilium, a little in front of the sacro-iliac synchondrosis. The bowel over it was very sensitive, but no perforation was discovered. Pressure over this portion of the bowel, however, caused emphysematous crackling; since then the patient believes that he has occasionally passed some urine per rectum, but this seems to be doubtful.

On December 11th, 1890, Dr. Gouley performed a supra-pubic cystotomy and removed several pieces of bone incrusted with phosphates and some phosphatic detritus. A digital examination of the bladder showed that there was an opening in the bladder on the right side in front of the sacro-iliac articulation. The bladder was adherent to the bone about the opening, which was sufficiently large to admit the end of the finger. At the bottom of this opening bare bone could be felt. An attempt was made to drain the bladder through this opening, but failed. Fluid injected into the bladder escaped through this opening and flowed out of the old sinus in the thigh.

The calculus matter and bone having been removed, the bladder was left open and a drainage-tube was introduced at the lower angle of the wound into the bladder.

The wound healed in about three weeks.

Since then the patient has been free from pain and has gained in weight.

At Dr. Gouley's request I examined the patient on Wednesday, March 11th.

The sinus in the thigh is still open and is drained by a large rubber drainage-tube. Through this sinus a large quantity of the urine passes. A probe introduced into the sinus passes upward and backward for about six or seven inches, and I could easily detect dead bone at the bottom. The opening into the bladder seemed to be in the ischium, a little in front of the right sacro-iliac articulation.

By rectal examination I failed to detect any denuded bone. The prostate is slightly enlarged on the right side and is abnormally hard. The left lobe is smaller than normal. Attempting to introduce a Thompson's searcher, the point was arrested in the prostatic urethra, and some manipulation with the finger in the rectum was necessary to make the instrument enter the bladder. The cause of this obstruction is not clear, but seems to be due to the deformed condition of the prostate produced by the calculus which I removed. No calculus

could be detected in the bladder, nor could any dead bone be discovered with the searcher. The tactile sensibility of the bladder is markedly increased. Its tension capacity is ℥ iv. Fluid injected into the bladder escapes through the sinus in the thigh, but fluid injected into the sinus does not now enter the bladder.

A careful cystoscopic examination showed an opening on the right side of the bladder, but the exact location of this I was unable to decide. The bladder was entirely free from calculus, except about this opening.

From the facts related in the above history, it would seem that there was first a necrosis of the pelvis, followed by perforation of the bladder, and the subsequent formation of calculi upon the sequestra as they separated. The case is now under the care of Dr. Gouley and further operative measures are under consideration. I have reported the history more for its peculiarities than for its instructive features.

95 PARK AVENUE.

AN INTERESTING CASE OF INHERITED SYPHILIS.*

By WM. L. STOWELL, M.D.

THE subject of inherited syphilis is not a new one, and I have no new theories to establish nor treatment to propose. The case I presented is one showing some interesting features, and will serve to refresh our minds on some symptoms and conclusions as to the disease.

The victim of his father's vices is familiar to all physicians of general practice in cities, though not so common in the country.

The undersized and weakly infant, with aged expression of countenance, the skin smoky on the prominent parts of face, the feeble and squeaking voice, and the snuffling nose, is a too common visitor to our dispensaries.

Most of the manifestations of congenital syphilis are of the secondary and tertiary stage. The boy before you presented both, and his history is as follows:

John B., aged 9½ years. The boy's father was a cab driver in London and known to be of irregular habits. Owing to illness which proved to be syphilis his wedding was delayed. About two months after marriage the mother was very ill with what was pronounced rheumatic fever and ulcerated sore throat. At the time a profuse eruption covered the entire body, and as the woman recollects, it was like a fine measles eruption. It remained out a week or more. Doubtless a roseola. Shortly after this attack ceased she became

[1] Presented before the Genito-Urinary Section of Academy, April 9th, 1891.

pregnant and later aborted at about fifth month of gestation. The hair nearly all came out and she suffered much from rheumatic pains.

Fifteen months later the present patient was born. At birth apparently well. When six weeks old an eruption appeared on hands, feet, and body which resembled "chicken-pox"—in other words, pemphigus, the most frequent form of eruption in congenital syphilis and usually earliest. At this time he was greatly troubled by snuffles. As the snuffles continued, the skin about the nose and mouth became excoriated and cracked. The pemphigus disappeared in three weeks. As this subsided the mucous patches about the mouth and anus extended to great thickening of the tissues, and deep fissures formed which bled constantly. It was with difficulty that the child was nourished.

In addition to the fissures in usual situations, the knees and elbows also suffered, and the resulting scars may still be seen, though not so numerous or deep as about the mouth.

When five years old a playmate threw a stone which hit him in the left eye. A severe inflammation supervened, which seemed to be aggravated by the syphilitic diathesis, and Dr. Knapp removed the globe to save the opposite eye.

At the usual time his second set of teeth appeared. The upper central incisors are short, narrow, and peg-like, and have a crescentic notch in the middle third. The lateral incisors are small and set irregularly. The lower incisors are small and have saw-tooth margins.

The boy suffered often from headache and has been under treatment for a year on that account. I thought it due to chronic meningitis and gave mixed treatment. He is free from pain when taking the medicine.

The interesting features to me were as follows:

Both parents had active symptoms of syphilis at first conception. The product, as might be supposed, perished at the fifth month.

The next pregnancy occurred when symptoms were less active. The child was born without rash, which appeared at most common time, six weeks, and was accompanied by very severe lesions of skin, which usually prove fatal because the patient cannot be properly nourished. Hence the deeply-scarred faces are not so common as those with depressed nose, etc.

Though full of the syphilitic poison, the bony system escaped, except the teeth, and these are just such as Mr. Hutchinson considers diagnostic. (Question: Will syphilis acquired before sixth month of life give peg-teeth?)

That the poison is not all eradicated is shown by the malignant inflammation and slow healing of any slight scratch or bruise.

When the patient was a few months old his father died of congestion of the lungs. Five years later the mother married a second husband, by whom she has two healthy children. She has had no miscarriage since second marriage.

Society Transactions.

THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY.

Stated Meeting, Thursday Evening, April 9th.

DR. R. W. TAYLOR, *President, in the Chair.*

DR. W. L. STOWELL presented a case of **Congenital Syphilis.** (See page 215.)

DR. KELSEY said that he would speak upon one point only, namely, the recurrent hemorrhages from the rectum. Hemorrhoids in children were practically unknown, and the source of the hemorrhage in the case under discussion was probably due to some ulcerative lesion. If the ulceration was caused by the syphilitic poison it would be a most interesting and convincing proof of the existence of syphilitic ulceration of the rectum which was sometimes denied.

DR. R. W. TAYLOR said that as a rule syphilitic pemphigus usually occurred early in the course of congenital syphilis. When it did occur the prognosis was usually bad. It was interesting, therefore, to notice in this case not only the late appearance of this symptom, but also the favorable outcome of the case.

DR. J. A. ANDREWS presented the following reports of cases, which were read by the secretary :

1. **Case of Chancre of the Conjunctiva.** Thomas L. R., aged 36 years, consulted me June 16th, 1884.

Abrasion situated in cul-de-sac of lower eyelid of right eye. Sore of a dusky red color, ovoid in shape, and three-eighths of an inch in its longest diameter. Pronounced injection of conjunctiva of lid, only slight injection of ocular conjunctiva below, near abrasion. The sore is raised above the surrounding conjunctiva and has a hard base. The appearance is not unlike that presented by an ulcer of a Meibomian gland, except that it is not connected with the cartilage of the lid and has an indurated base. The sore occasions no pain, but "the eye feels as if there were something in it."

About three weeks before coming to me, patient states that while at work in his shop a piece of iron-filing flew into his right eye. He saw the foreign body in a glass and tried to remove it with a corner of his handkerchief, but did not succeed, whereupon a fellow-workman volunteered to try to dislodge the foreign body with his tongue, a practice in vogue in a machine shop where he had formerly been employed. After several attempts with the tongue the foreign body was lost sight of.

The swelling in lid was first noticed two days before consulting me, and patient thought it had been occasioned by the foreign body. No induration of pre-auricular ganglia at this visit.

The appearance of the swelling, together with the induration and history of the case, excited the suspicion that the sore was a chancre. Patient was directed

to wash the eye with a solution of boric acid, and the man who had removed the foreign body with his tongue was sent for. He came only two weeks later, when he showed unmistakable signs of secondary syphilis.

Patient was lost sight of for a while. When he came to me on August 12th, 1884, he presented a typical roseola. Later, general glandular enlargement, etc. Patient remained under observation for eighteen months, and was, when last seen, apparently in good health, without any signs of constitutional disease.

DR. TAYLOR had seen four cases of this variety of primary lesion. The mode of origin—viz., the use of the tongue to remove a foreign body from the eye—was interesting. About three years ago in Russia there occurred a number of cases of syphilis in a small village. All of these were due to this practice of removing foreign substances from the eye.

II. **Calculi in the Prepuce.**—Patient was 38 years of age, native of Sin-huin district, about 100 miles west of Canton, China. The prepuce was greatly thickened and enlarged, and the presence of calculi was discovered with a probe. Circumcision was performed, July 11th, 1862, by Dr. Kerr, of the Canton Mission Hospital. The operation consisted of making crucial incisions in order to remove the calculi, after which circumcision was performed, by which the superficial thickened skin was removed. The calculi were two in number, and the weight of both was one ounce two drachms and two scruples. The diameter of one was one and five-eighths inches by one and one-eighth inches; it had two concave facets, one on each side. One was smooth and on it had rested the other stone. The facet was partly covered by a deposit and evidently had been rubbed by the second stone at some former time. The second stone was one and one-half inches in diameter, and was almost a perfect double concave lens in shape. One of its sides, where it rested on the facet stone, was worn quite smooth.

The calculus herewith presented is a reproduction in plaster-of-Paris made by myself at Canton, China, in 1882, from the original calculus in the possession of Dr. Kerr, of the Mission Hospital at Canton, China. I regret that the companion calculus has been lost.

DR. ALEXANDER said that the occurrence of calculi in the prepuce was comparatively rare, although there was frequently to be found in the cavity of the prepuce a deposit of phosphatic salts in cases of phimosis and with a narrow preputial orifice. He recalled the case of a child in which he had removed a large amount of smegma and phosphatic salts from the cavity of the prepuce. In this case the orifice was so narrow that the prepuce was distended with urine at each act of micturition.

DR. TAYLOR had seen a number of similar cases, one of which was a man aged 42 years. From the cavity of the patient's prepuce Dr. Taylor removed a large quantity of a substance resembling asbestos, which consisted of decomposed smegma and phosphatic salts.

Chancre of Rectum.—By FRANK HARTLEY, M.D. J. McG., 32, male, U. S., organist, was admitted to Roosevelt Hospital, September 20th, 1890.

Family History.—No tubercular, renal, nor cardiac ailments. No rheumatic history.

Personal History.—No tubercular, renal, nor cardiac disease. Denies all previous venereal diseases. Had dysentery some years ago.

Present Condition.—About three weeks ago patient noticed severe pain at defecation and a small lump just within the anus; pain now continuous. Tenesmus after each passage. Blood has been present at stool at times. He has suffered from constipation for a long time.

Examination.—An ulcer is found just one inch from the anal margin. It is about the size of a quarter of a dollar. The base is indurated and the ulceration is very superficial. Sacral glands felt enlarged. There is no evidence of any other lesion.

Operation.—Sept. 20th. Dr. F. Hartley. Usual antisepsis. Bichloride and boric acid irrigation of the rectum, sphincter dilated. Bivalve speculum used. The ulcer is seen just one inch within the rectum; it is superficially eroded with a distinct but not cartilaginous base.

Excision of Ulcer.—Cauterization with Pacquelin cautery. Iodoform powder. Suppository of opium gr. ij.; opium pill gr. i., t.i.d. Patient ordered to wards and to be watched for any evidences of syphilis. September 25th. Movement of bowels. Daily irrigation. September 30th. Ulcers healing rapidly. October 1st. Roseola over the surface of the chest and abdomen. October 5th. Discharged from hospital improved. October 20th. Patient applied to-day for treatment in the out-patient department, stating that his medicine had been used up and that he desired more. Patient presents a papular syphilide involving the face, forearm, trunk, and portions of the extremities. The ulcer of the rectum is healed. Patient is put upon antisyphi litic treatment.

A careful inquiry as to the mode of infection was instituted. Patient for the first time during his treatment here admits that three weeks before admission to the hospital, while in Baltimore, he was the victim of another man.

After this confession the patient was lost to view.

Gonorrhœa in Women.—DR. A. F. CURRIER read a paper on this subject.

DR. BREWER desired to oppose the opinion which has been prevalent for so long a time that gonorrhœa in the female necessarily indicated a vaginitis. It had been demonstrated by Bumm and others that the gonococcus will not develop upon the pavement epithelium of the vagina, and that the urethra in the female, as in the male, was the primary seat of the disease. The neck of the womb was another favorite situation of the disease, but the vagina was only affected as a complication, just as balanitis occurred as a complication in the male.

Some years ago he had the opportunity of examining a number of women from whom the disease had been contracted, and who were supposed to be quite healthy. Among thirty women examined gonococci were never found in the vaginal secretion, but invariably so in that from the urethra and occasionally in that from the cervical canal.

DR. W. K. OTIS thought that infection in either men or women rarely occurred during the acute stage of the affection.

It was very difficult to determine the presence of a contagious discharge in women, for as a rule they used a douche or syringe before the examination and thereby removed all evidence of the disease.

A little pus could, however, frequently be pressed out of the glands of Bartholini and the presence of gonococci demonstrated in it.

He agreed with Dr. Brewer that the urethra was primarily the seat of

the disease, and the vagina rarely affected. In regard to affections of the tubes and ovaries, he thought many bacteriologists regarded them as due to secondary infection with other micro-organisms after the way had been opened by the gonococci.

DR. ALLEN had occasion several years ago to examine the secretion from a number of women while working up the subject of the gonococcus. He failed, however, to obtain satisfactory results from the vaginal secretion, as it was difficult to say whether the masses of diplococci found were Neisser's gonococci or similar forms.

DR. BROWN differed from Dr. Brewer in that he thought the cervix was more frequently affected than Dr. Brewer's remarks would lead one to infer.

He gave in detail the history of an interesting case in which a pregnant woman had been infected by her husband with gonorrhœa, where the opportunity had been afforded him of seeing the case in its inception, and of making a careful microscopic examination of the secretion from the vulva, vagina, cervix, and urethra.

Gonococci were found in greatest abundance in the secretion taken from the cervix and from the vagina just beneath the cervix; they were absent from the urethral secretion.

Two weeks after the onset of the attack the secretion from the cervix failed to show any gonococci. The subjective symptoms had been slight.

DR. BACHE MCE. EMMETT said that since Dr. Noeggerath had expressed his views he thought every gynæcologist had been on the alert to detect such cases of infection with latent gonorrhœa, and the influence of the disease in producing affections of the urethra and its appendages.

While it was true that the gonococcus could be carried into the upper portion of the cervical canal, into the body of the uterus, and presumably to the tubes, it was his opinion that its importance in this regard had been largely overrated.

He had to-day seen a case which came into the hospital giving a clear history of gonorrhœal infection. She had a leucorrhœal discharge, and persistent pain in both ovarian regions since her marriage, five years previously. Examination showed decided enlargement of both sides of the womb.

The case was operated upon, and both ovaries and tubes removed.

One ovary showed a cystic degeneration, the other a decided ovarian cyst; the tubes were free from pus.

The case showed how easily it was to attribute to gonorrhœa affections which are entirely independent of it.

DR. KELSEY had been led to believe that the presence of gonococci in a discharge was positive proof of its gonorrhœal nature.

In the few cases of specific proctitis that he had seen the diagnosis rested upon one fact— the existence of the gonococci. Specific inflammation of the rectum was an extremely rare disease, and in severe cases the diagnosis might be made without the microscope by the intensity of the inflammation and the peculiar greenish color of the discharge. A differential diagnosis between a mild case of gonorrhœal proctitis and a severe case of simple catarrhal inflammation of the rectum could not be made without the assistance of the microscope.

Gonorrhœa of the rectum is rare in this country because the practice of unnatural vices is rare. He has never accepted the writings of the French

as applicable to our own country. In the cases of gonorrhœal proctitis that he has seen he has been able to obtain a history of unnatural practices, but it is useless to accuse a patient of such vices.

DR. TAYLOR thought the postulate of Bumm and Steinschneider, that the vagina was not pervious to the ravages of the gonococcus, was only true of the healthy vagina.

A chronic congestion or abrasion of the mucous membrane might easily open the way for infection. In examining a woman for gonorrhœa it was better to make the examination in the Sims position, as in the usual position, with the patient on her back, the uterus was apt to rest on the posterior vaginal wall and cover up the posterior cul-de-sac.

He spoke of the imperfect details which are usually obtained regarding the mode of infection, the period of incubation, and the early history of the affection. Many cases were called gonorrhœa which were simple cases of hyperæmia of the genital tract.

In the treatment of gonorrhœa in women he thought every case should be studied as to whether it was a gonorrhœa of the vulva, the urethra, an affection of Bartholini's glands, of the upper or lower segment of the vagina, or of the cervical canal. He did not think it a good statement to make that balsamics are to be entirely discarded in the treatment of gonorrhœa in women, as when the urethra was involved they were capable of rendering good service.

In speaking of the relationship of the gonococcus to the affection, he referred to the fact that a number of late investigators had found a micro-organism on the genitals of young children who had never been exposed to contamination, which could not be distinguished from the gonococcus. As the discovery of the gonococcus in young children often carries with it the imputation of rape, the medico-legal importance of this question was apparent.

The gonococcus might be the pathogenic factor in the disease, but there were observations which seemed to prove that it may be a saprophyte existing in the healthy or damaged urethra ready to be fanned into activity by prolonged venery, the use of stimulants, etc.

DR. CURRIER said, in closing the discussion, that it was a matter of little practical importance whether the gonococci developed upon the pavement epithelium of the vagina or whether they were derived from the pus of the cervix uteri.

His experience had been that the proportion of cases in which the clinical phenomena suggested an involvement of the urethra were quite small. In the majority of cases we were guided in our diagnosis by the clinical phenomena present.

He said if we admitted the correctness of the cultivation and inoculation experiments, we were forced to the conclusion that the gonococcus was the pathogenic agent in the disease. In medico-legal cases it would be necessary to exercise unusual caution in giving an opinion based on the microscopic examination of the secretion alone.

Regarding the involvement of the pelvic organs in women, such cases as the one quoted by Dr. Brown proved that the envelopes of the fœtus act as an effectual barrier against the invasion of the uterine canal by the gonococcus.

He believed the disease spread from one epithelial cell to another, so that it was not difficult to understand how it could traverse the entire genital tract.

NEW YORK DERMATOLOGICAL SOCIETY.

207TH REGULAR MEETING.

DR. E. B. BRONSON, *President, in the Chair.*

Prurigo Hebra.—Presented by DR. G. T. ELLIOT, with the following history :

Boy, 16 years of age, native of Galizia, developed the disease at age of two. It has existed ever since, better at times, then again relapsing. He says that it is always worse in summer and much less severe in winter. Patient is fairly nourished ; entire surface dark in color, with large areas where pigmentation is more marked. The skin of extensor surfaces of extremities is thickened, especially on legs, the hairs dystrophic, while distributed over them are papules, size of small pea, pale red or whitish in color, scratch marks, and small areas of eczema. On the face and trunk are similar lesions. The popliteal spaces, Scarpa's triangles, bends of the elbows are free. In the region below Poupart's ligaments are large masses of enlarged glands. Pruritus is a most marked and prominent feature of the process.

The members of the society concurred in the diagnosis.

Case for Diagnosis.—Presented by DR. KLOTZ.

The patient, John G., 49 years of age, born in Germany, a cabinet maker, has been generally in good health. His wife had been sick for ten years when she died, several months ago, but not with consumption, as far as can be ascertained. Not long before Christmas he cut himself with the razor on the chin while shaving. The wound has never entirely healed, but forms a small, wart-like prominence, hard to the touch, not sharply defined, covered with a small crust, not oozing. Soon after New Year a small nodule appeared on the septum of the nose, which has increased gradually to the present condition, when the entrance to the right side of the nose is surrounded by a dark red infiltration, rising somewhat abruptly at the circumference and showing a slightly scaly surface, reaching from the septum nearly to the ala nasi, and extending about equally to the lip and into the interior of the nose. The nose itself shows the tip of a dark red color, rather hard and tensely infiltrated, with thin gray scales ; and on the border, which is not well defined, a number of small dark-red nodules, round, with small crusts, resembling pustules, but exhibiting no moisture on scratching. The affection has not been treated so far except with vaseline, and on account of its probable origin seemed of interest enough to be presented here. It seems hardly doubtful that the affection is one of tubercular infection, although the history does not afford a clue to the source. I do not think it makes much difference whether you call it lupus or tuberculosis verrucosa cutis. I intend to treat the patient in the hospital, if he consents. I should first use the Pacquelin and destroy as much as possible of the new growth, then cover it with salicylated plaster, and after about a week begin injection with tuberculin, not so much on account of the therapeutical effects, but to define the extent of the disease as far as possible and then to attack it again with the thermo-cautery. This, after Bergmann's most recent publication, seems to be all that is to be expected from the tuberculin for lupus.

DR. MORROW thought it was one of the cases in which it would be difficult to arrive at a positive diagnosis without the intervention of time or treat-

ment. He referred to the possible specific nature of the affection, but said that the history was against that view.

DR. CUTLER said he looked upon the disease as syphilitic.

DR. KEYES considered the trouble as a late syphilide and having nothing to do with the cut on the chin. He would advise resorting to mixed treatment before using local remedies.

DR. ALLEN agreed with Dr. Keyes. He was impressed by the "moth-eaten" appearance of the hair on the back of the head. The lesion on the nose did not look like an ordinary late tubercular syphilide; still he would desire to exclude that disease before regarding the affection as a tuberculosis.

DR. FOX said that the rapid development of the disease would almost verify the syphilitic nature of the affection. The history of the case would have little influence with him in serving as a basis for diagnosis.

DR. KLOTZ had seen the case but once before. The appearance of the lesion suggested to him a local tuberculosis rather than syphilis.

Case for Diagnosis.—Presented by DR. BRONSON.

The patient was an Italian woman, aged 43. About three years ago her health began to fail following a severe nervous shock. First she observed a numbness and tingling of different parts of the body, especially of the hands. It lasted for a year. Was temporarily relieved then by sea-baths, but afterward returned and was accompanied with stiffness and crackling of the joints, particularly of the wrists and fingers. The hands became swollen and over the fingers the flesh became very hard. A similar hardening of the tissues affected the lips. Scaly, red eruptions affected the nape, scalp, and hands, and the hair became very thin. About two years ago first noticed dusky discolorations on the chest and abdomen. Has suffered generally from increasing feebleness, loss of appetite, etc. At present there is a decided melasma of the skin over the abdomen and about the waist, over the neck, and in less degree over other parts of the body. Upon the chest, together with the blackish discoloration, there is a decidedly reddish hue, apparently due to multitudes of little arterioles that seem to be displayed in consequence of an atrophy of the epidermis. In other places the skin seems very thin and atrophic. On the face large blue veins show plainly, but patient states that this is family peculiarity. Over the scalp and extending down over the neck is a scaly eruption that shows distinct redness underneath the rather thin and closely adherent scales, and upon the scalp there is some swelling with pitting on pressure. On the nape the eruption is sharply defined and bordered by gyrate lines. On the backs of the hands are scaly patches like those on the neck. In none of these places is there any appearance of eczema. The skin over the hands and especially the fingers is markedly condensed. The fingers are bulbous and hard and cannot be entirely closed. The nails are claw-shaped and one of them (left ring finger) is decidedly atrophic. On the balls of two or three fingers there are small depressed scaly spots apparently atrophied. Over one of the knuckles there is a transverse fissure with thin depressed edges. The lips are thin, dense, and inelastic. Patient complains that she cannot "suck an egg." She also complains of poor digestion, loss of appetite, and pains at the articulations.

DR. LUSTGARTEN regarded the case as pellagra, as in the first erythematous stage lesions were especially developed over the parts of the body exposed to the sun.

He would expect, were she under the influence of the same poison, that

further symptoms would develop, such as atrophy, pigmentary changes in the skin, and other tropho-neurotic symptoms. He asked how long she had been in this country, and if she had lived upon polenta.

DR. BRONSON replied that she had never eaten it.

DR. LUSTGARTEN said that the swelling of the tips of the fingers reminded him of tropho-neurotic changes like in sclerodactylitis.

DR. ALLEN was inclined to agree with Dr. Lustgarten. He had seen a similar affection at Charity Hospital in an Italian which he regarded as pellagra. This case did not resemble the cases of scleroderma usually seen.

DR. BRONSON had thought of pellagra when he first saw the case, but he was under the impression that pellagra was accompanied by more erythematous manifestations than in this case.

There had been certain isolated red spots on the scalp and hands, but the main feature of the case had been an atrophy of the deep and superficial layers of the skin.

Disease of the Hand.—Presented by DR. BRONSON for diagnosis.

DR. JACKSON looked upon the condition as the result of a local infection.

DR. TAYLOR had seen a similar condition affecting the metacarpal bones.

DR. ELLIOT had noticed brown-red lesions resembling lupus tubercles above the cicatrix of the incisions which had been made on the dorsum of the hand. He thought the entire process was a tuberculosis which had affected the sheaths of the tendons in the palm of the hand, and secondarily the tissues lying above them, and in places the skin also.

DR. KEYES had seen a case which resembled this one in its gross appearance. It affected the great toe and was complicated with several dermic abscesses. He had treated the case by means of the multiple punctate thermocautery and obtained apparently a cure.

DR. CUTLER considered the case one of local tuberculosis, affecting the skin and deeper tissues.

DR. MORROW regarded it as a case of local tuberculosis, but thought the diagnosis would lie between tuberculosis and malignant neoplasm.

"Cause of Death following Extensive Burns and a Possible Antidote for the Same," was the title of a paper read by DR. LUSTGARTEN.

DR. ALLEN spoke of the beneficial effects which he had observed from the use of the continuous water-bath in cases of extensive burns, and thought it would be a desirable feature to introduce into the hospitals of this country.

DR. G. H. FOX read a preliminary report on the use of an Irish moss plasma as an ointment base, and detailed a number of cases showing in what respects the new base was superior to the old ones.

DR. ALLEN said that while he did not think it desirable to obtain a systemic effect from the remedies used upon the skin, he did think, in the majority of cases, that the remedy should penetrate the skin tissue and not alone exert its action upon the outer epidermis.

In a number of cases he had been much pleased with the new base, especially in cases where salves or plasters would have been inconvenient to use.

DR. ELLIOT said that it was necessary, in comparing the preparation presented by Dr. Fox with bassorin paste, to consider in the first place what was the object of each of them. The bassorin paste was intended to furnish a base which, taking up any drug incorporated with it, would dry upon the surface and keep the medicament in contact with the diseased skin, while Dr

Fox claimed that his base penetrated into the skin. Under such circumstances, it was necessary to choose the cases upon which to apply each, and to use the one where surface application was necessary, the other where penetration was desired. He thought both would have their uses, but neither one nor the other were to be regarded as universally applicable. He would also add that Dr. Fox referred to bassorin as a secret preparation. It could not be so called, however, inasmuch as the constituents of the paste were given, and bassorin itself was known as a vegetable mucilage obtained from gum tragacanth (*Vide* Dr. Foster's Med. Dictionary).

DR. MORROW suggested that Dr. Fox institute some experiments in the treatment of syphilis with mercury in combination with the new base in comparison with the treatment by the ordinary mercurial ointment.

He thought there was a great deal of false theorizing relative to the absorbability of the various excipients used. The impression was general that vaselin was not so readily absorbed as lard or lanolin, and yet certain recent experiments showed that vaselin and drugs contained in it were much more readily absorbed than lard or lanolin.

DR. PIFFARD stated that he had devised a new ointment base which he had used with some satisfaction.

The objection to both lard and lanolin was that they were too greasy and the lanolin of to-day was much softer than formerly and more disagreeable on that account.

If a small quantity of pure muriatic acid be added to lanolin it formed a waxy mass which makes a very adhesive salve and did not give any of the characteristic muriatic-acid odor.

DR. SHERWELL thought the new excipient bases would have a limited field of usefulness, but did not believe they would ever be substituted in general use for the fatty ointments.

He used cold cream very frequently as an ointment base and found it very satisfactory.

DR. JACKSON had made some comparative tests with bassorin paste and plasment, and found in one case of chronic eczema of the lower extremities that the bassorin paste gave better satisfaction to the patient. He thought, as a rule, the bassorin paste was applied too thickly, instead of being lightly spread over the affected part.

DR. LUSTGARTEN had used bassorin paste, but did not think it would ever be a substitute for the fatty ointments. In certain cases where protection was required it might be used to advantage.

All the substitutes for salves that had been introduced in recent years have not proved satisfactory.

He thought the base would continue to be a fatty salve and especially one of lanolin.

Selections.

The Frequency of Affections of the Posterior Urethra in Gonorrhœa. (*Centralbl. f. d. Physiol. und Patholog. d. Harn- und Sexual-Organe.*)

In a paper read at the 63d meeting of the Society of German Naturalists and Physicians, Dr. G. Letzel calls attention to the superficial character of most of the examinations made in persons suffering from gonorrhœa. He

states that irrigation of the anterior urethra for the purpose of determining the condition of the posterior portion of the canal is only practised by a small minority of physicians, although it is one of our best means of diagnosis. The author washes out the anterior urethra with sterilized water, making use of an ordinary syringe holding about one hundred cubic centimetres; the injections are made with considerable force and repeated several times. The bulbous portion may then be wiped clear of mucus by means of an elastic bougie-à-boule. In this manner we can cleanse the anterior urethra of all secretion, and if we then allow the patient to urinate the urine will contain pathological elements only from the membranous and prostatic portions.

For the purpose of estimating the frequency of disease of the posterior urethra during the course of a gonorrhœa, the author made a study of fifty-three cases, selecting only those which came under treatment from seven to ten weeks after infection, and in which there were no subjective symptoms pointing to disease of the posterior portion of the canal. Among these he found only four in which this complication did not exist—*i.e.*, only 7.5 per cent remained exempt. This high percentage of cases of posterior urethritis demonstrates the necessity of carefully examining the posterior urethra in patients with gonorrhœa. A posterior urethritis is comparatively easy to cure during the first few weeks of its existence, while if it is overlooked and allowed to become chronic its treatment is attended with difficulty. It behooves the general practitioner, therefore, to examine the posterior urethra in all cases where a gonorrhœa has been present for more than six weeks.

As regards the therapeutics of posterior urethritis, the author employs instillations, according to Guyon's method, of a ten-per-cent solution of resorcin, injecting four to five grains into the posterior urethra during gradual withdrawal of the instrument. This causes practically no irritation in the majority of cases. The injections may be repeated daily, and frequently will effect a cure in about three weeks. Of course, during this time any inflammation of the anterior canal should be treated by injections. If the resorcin should prove inefficient it may be replaced by one-fourth to one-half per cent solutions of nitrate of silver, which should be instilled every two or three days when all previous irritation has disappeared. Letzel has also employed with success five to ten per cent solutions of thallin sulphate, but the effect was not prompt and irritation was sometimes observed. Another serviceable means of treatment is the use of five-per-cent prostatic antrophores of resorcin, or containing in addition 0.5 per cent of zinc sulphate or five per cent of tannic acid. These may be intrusted to the patient, and thirty antrophores will frequently effect a cure. Before they are introduced the bladder is always to be emptied, and they are left in the urethra for from five to eight minutes, which is sufficient for their solution. If allowed to remain for a longer time they produce more or less irritation and have to be discontinued. Not more than one should be used each day. F. TILDEN BROWN.

The Occurrence of Microcytes in Bloody Urine. S. ROSENSTEIN. (*Internat. Centralbl. f. d. Physiol. und Pathol. der Harn- und Sexual-Organe*, Band II., Heft 2.)

Although in many cases the complex of symptoms accompanying hæmaturia is sufficient to demonstrate with approximate certainty the source of the hemorrhage, there remain quite a number of cases in which errors of diagnosis are liable to occur. Cases of hæmaturia are not infrequently

observed when the symptoms seem to point to the bladder as the source of the hemorrhage, although renal calculi are found to be the cause of the trouble. Hence attempts have been made to determine the source of the bleeding from the character of the urine, independently of the other symptoms. As early as 1867 Traube regarded amœboid movements of the red blood-corpuscles and segmentations of the same as a diagnostic sign of renal hemorrhage. Later investigations showed, however, that these conditions occurred both in renal and vesical hemorrhage and were due to the general constitutional state. Traube considers the shape of the corpuscles—the so-called shadow rings—as a sign that they are derived from the kidney, while the absence of changes would indicate their origin from the bladder. The time during which the blood has remained in the bladder, however, has much to do with this. Unchanged chromocytes may be found in renal hemorrhages if the blood is rapidly voided, and altered corpuscles are present if it has been in the bladder for a long time before evacuation. The author brings forward as a new sign of diagnostic importance the abundant occurrence of microcytes which he has found in vesical hemorrhages due to malignant growths. It has been maintained that microcytes are artificial products forming on the cover-glass, but although this is possible, it cannot be the case in the instances observed by Rosenstein where the microcytes were observed in the urine immediately after its evacuation and evidently resulted from the new growth of vessels in the neoplasm.

In the case of a man sixty-six years of age, who had suffered for two years from hæmaturia, the urine contained, besides red blood-corpuscles of the ordinary form and size, numerous others which had a circumference of only 0.002 mm. and were without a central depression. Later fragments of a new growth were found, together with numerous microcytes, while the larger blood-corpuscles showed amœboid movements. At the autopsy a papillary cancer of the bladder was found, with degenerative changes in the kidney. In a number of cases of benign papilloma the occurrence of numerous microcytes was also demonstrated. It seems as if this new diagnostic sign might be of value in calling attention to the presence of a vesical neoplasm at an early period. F. TILDEN BROWN.

Aristol in Venereal and Cutaneous Diseases. DR. G. SALSOTTO, of Turin. (*Gazetta Medica di Torino*, October 5th, 1890.)

The author has tried aristol in the treatment of syphilitic ulcers of various stages of the disease and in gonorrhœa. He found aristol of but slight efficacy in the typical syphilitic ulcer, where he places its action still below that of iodol, which is probably due, he says, to it not liberating nascent iodine in the presence of organic fluids, for which reason he abandoned its use in this disease.

He cites the history of six cases, which were either interesting because of their complications or of operations done, in which aristol had a beneficial action.

In the first there was an extensive gangrenous ulcer occupying the whole of the right labium minus and extending also into the vagina. The grayish plaque forming the base of the ulcer was curetted away and the vagina was packed with absorbent cotton dipped in the powdered aristol. This dressing was renewed twice daily. By the third day the gangrenous ulcer was converted into a simple ulcer. He also obtained good results in twocases of

ulcerating gumma of the penis, in a case of initial syphiloma, in another of gangrenous ulcer, in two cases of ulcerating gumma of the tibia, etc.

In urethritis it cannot be employed because of its lightness, which prevents its being suspended in water even upon shaking, hence rendering its employment in injections impossible. Two cases of balano-posthitis were cured in two days, four cases in three days, by dusting the remedy into the preputial sac after previous irrigation and drying.

Hence the writer regards aristol as a good antiseptic and one of the best topical remedies.

PROF. A. BREDA, of Venice (*Revista Veneta di sc. med.*, November, 1890), had occasion for five months to employ aristol as powder, in ointment, and in collodion upon eighty patients in all, twenty-seven of whom were seen in the hospital and the remainder in private practice. It was tried in erosive preputial herpes, in balano-posthitis, in intertrigo, in excoriations due to dysidrosis, in burns of the second degree, in anal rhagades, in nasal erosions from freezing, in venereal ulcers, in cavities from phlegmonous adenitis and following enucleation of glands, in ulcers of the legs from phlebectasia or deep abscesses, in ulcers with sinuses or caries of the tarsus. It was also experimented with in lupus tuberculosis and lupus tuberculo-ulcerosus of the skin and septum narium, in primary solitary ulcerous lupus of the epiglottis, in diffuse rhino-laryngitis as well as in the superficial, atrophic, chronic, and fœtid forms. The following are the results obtained by the writer.

Aristol undergoes visible changes on exposure to light. It is odorless, always dry, extremely divisible and light; it is easily distributable with the brush and insufflator on the skin as well as in the nasal and laryngeal cavities. No patient presented the slightest sign of any disagreeable, much less of an irritating or toxic action. In some of the cases traces of iodine were to be expected in the urine, but it could not be detected. In herpes, in erosive balano-posthitis, in inducing cornification in dysidrosis, in intertrigo, and in burns the remedy acted promptly and satisfactorily. In venereal ulcers it was efficacious, especially after destruction of the virulence of the focus. The surface of the ulcer, whatever the nature, seat, or size, kept itself dry and clean, and in general reacted better than under iodoform. In one word, aristol possesses in a high degree the power of causing cicatrization of ulcers and solutions of continuity after previous destruction of their virulence, and, as Seguier says, it is an *epidermisateur* of the first order.

DR. SEGRÉ, of Milan (*Boll. della Poliambulanza*, September and October, 1890), obtained but very slight effects from the use of aristol in balanitis and balano-posthitis; in initial gummata it exhibits but little action; in ulcerating gummata it rapidly cleans the surface of the wound and induces it to take on a good aspect. It acted best in ulcers where the latter were preliminarily freed of the venereal virus by means of some caustic, in adenitis, and in general in all superficial suppurations.

He concludes that it may be efficaciously substituted for iodoform, as it possesses all its advantages and has neither the disgusting odor nor the dangers of iodoform.

DR. SORMANI, of Milan (*Boll. della Poliambulanza*, September and October, 1890), says from the results which he obtained with aristol in the cutaneous department of the Milan Hospital, one may regard it as more than doing what was expected of it. He then gives the history of several clinical cases. The first was that of an ulcerating epithelioma. Aristol was used

first in powder and then in a (10%) salve. After only six days' use cicatrization of the ulcerated borders had taken place to a remarkable extent. By the thirty-fifth day cicatrization was complete. The second was that of lupus of the face, which healed well; another similar case is cited, which also healed under the influence of the remedy. The fourth concerned a scrofuloderma of the dorsal region of the right foot, which also was caused to heal. The fifth was a case of ecthyma where success was complete and rapid. The writer then mentions numerous cases of varicose ulcers which rapidly cicatrized under the influence of aristol salve. PICK AND PRITCHARD.

Balsam of Peru in Lupus and Venereal Ulcers. PROF. DE AMICIS, of Naples. (*Supplémento alla Gazetta degli Ospitali*, September, 1890.)

The author, after the good results of Prof. Annibale de Giacomo with balsam of Peru in the treatment of tuberculous lesions, experimented with the remedy in ulcerating venereo-syphilitic and lupous processes. He concludes as follows:

1. Balsam of Peru favors decidedly the process of reparation in ulcerating syphilitic lesions.

2. It influences favorably the reparative process in lupous ulcerations, but it does not seem to have any notable action on the lupous process. More observations are, however, necessary in order to settle this.

3. It does not modify the stage of ulceration of the simple contagious ulcer, yet it acts not a little upon the process of repair after destruction of its virulence by a caustic. PICK AND PRITCHARD.

Electric Cataphoresis in the Treatment of Dermatomycoses. DR. CIARROCCHI, of Rome, (*Gazetta Medica di Roma*, September 1st and 15th, 1890.)

The author has employed electric cataphoresis in several dermatomycoses and arrives at the following conclusions:

1. It is evident, from the observations of others and my own, that the employment of electric cataphoresis in the treatment of dermatomycoses yields results which are most satisfactory and superior to all other methods of treatment.

2. The use of a solution of corrosive sublimate (1%) applied to the anode is of great utility.

3. The length of time required to effect a cure is much less than ordinarily necessary with other methods. This period might be even more shortened if the cataphoretic sittings could be made more frequent, which up to now has been found impossible, as parasiticides more innocuous to the organism and methods of gaining greater tolerance of the patients are yet to be discovered.

4. This method of treatment is accompanied by no disagreeable symptoms, neither local nor general; only it cannot be denied that often in children with especially sensitive skins the burning sensation from the penetrating sublimate is painful, and sometimes even unbearable.

The writer first employed a cap of absorbent cotton dipped into a solution of corrosive sublimate, but lately he has used an indifferent electrode designed by Dr. Pio Masetti and presented by him to the Società Lancisiana of the hospitals of Rome. This electrode consists of a good-sized bag of porous parchment which is filled with liquid and then easily adjusted to any part or the whole of the head. It much diminishes the burning sensation produced by the sublimate

solution, especially if filled with hot water which also at the same time has the advantage, as Dr. Stefanucci-Ala has demonstrated, of being a more powerful parasiticide. PICK AND PRITCHARD.

A Short Notice in Regard to the Treatment of Rodent Ulcers with Unna's Resorcin Plaster Mull. C. BOECK. (*Monatsh. f. prak. Dermat.*, Bd. XII., No. 2.)

Dr. B. reports two cases in particular, and states that he has had a number of others which have been cured by this method of treatment.

The first patient, male, aged 72, had a rodent ulcer 1½ square inches on his cheek. It had existed ten years and had led to complete ectropion of the lower lid. The resorcin plaster was applied to the entire surface and changed every day. Improvement manifested itself in a few days, and at the end of two months the ulcer was skinned over, only here and there a few small moist points remaining.

The second case, also a male, aged 82, had a small beginning rodent ulcer on the temple. The resorcin plaster was applied in December (date not given), and when seen on January 18th the ulcer was completely healed.

(In an article in the same number, based upon Boeck's paper, Unna confirms the latter's experience and testifies the good results obtained from the resorcin plaster.) GEORGE T. ELLIOT.

Zur Aristolfrage. DR. WEISSBLUM. (*Viertelschft. f. Dermat. u. Syph.*, 1891. Heft I.)

The results obtained from the use of aristol in psoriasis, eczema, favus, and other cases are given. The drug was used incorporated in olive oil, vaselin, lanolin and vaselin in the proportion of 1 : 3, and ungt. simp. in the strength usually of 10 per cent, in some cases 20 per cent. The application was rubbed in with a bristle brush frequently twice a day. Eight cases of psoriasis were treated with aristol alone. In three light ones, fading out of the lesions was obtained in respectively two, four, and fourteen weeks. In five severe cases no impression had been made after four weeks and even ten weeks.

Twelve cases of psoriasis were treated on one half of the body with aristol, on the other half with pyrogallic acid. In eight light cases the effect of the pyrogallic acid in from two to five weeks was most decidedly greater. In severe cases no effect from aristol at the end of four weeks. On the scalp and face aristol acted quite satisfactorily in two cases.

Several patients were treated for the sake of comparison with 10 per cent aristol and two to five per cent hydroxylamin. The latter had to be given up in a week or two on account of severe dermatitis ensuing; the former exerted no effect even when used for eleven weeks.

The conclusion drawn from these experiments is that aristol is of use in light forms of psoriasis and when a rapid cure is not called for. Also on uncovered regions it is of some value.

In eight cases of eczema aristol was used. Of these some were seborrhoic eczemas, others chronic trade eczemas. The results were very good. In three cases of favus and one of alopecia areata, no particular effect.

The drug was also applied to a case of rebellious ulcerating gummatous syphilis for three weeks, without any change being observed in the lesions. GEORGE T. ELLIOT.

Treatment of Urticaria. (*La Tribune Médicale*, Jan. 1st, 1891.)

Quinquaud recommends in cases of intermittent urticaria, quinia, but preferably arsenic. In the chronic form, baths and hydrotherapy in all its forms are to be absolutely forbidden. On the other hand, wrapping the patient up in cotton batting is often excellent. Internally alkalies, arseniate of soda, naphthol, are indicated.

For the pruritus he advises:

℞ Aq. lauro-cerasi, ... 50.
Chloral, ... 5.
Aquæ, ... 200.
M.

Or,

℞ Ether, ... 30.
Tepid water, ... 60.
M.

Also a powder for dusting on the surface:

℞ Amyli, ... 50.
Zinci oxid., ... 10.
Or Acid. salicyl., ... 5.
M.

When fresh outbreaks supervene, one-fourth of a milligramme of aconitine in divided doses will prove serviceable. GEORGE T. ELLIOT.

Abortive Treatment of Herpes. H. LELOIR. (*La Tribune Médicale*, Jan. 15th, 1891.)

Leloir recommends a small piece of gauze soaked in one of the following solutions to be applied:

℞ Resorcin, ... 100.
Alcohol (90%), ... 2.
M.

Or,

℞ Menthol, ... 1.
Alcohol (60%), ... 100.

If there is much pain use can be made of

℞ Cocainæ muriat., ... 1.
Ext. cannabis indic., ... 10.
Essen. menth. pip., ... 10.
Alcoholis (90%), ... 100.

GEORGE T. ELLIOT.

Treatment of the Chancroid. DU CASTEL. (*La Tribune Médicale*, Jan. 1st, 1891.)

After reviewing the various procedures recommended and in use, he states that for several years he has used a solution of

Alcohol (90%), ... 10 parts.
Crystallized carbolic acid, . . . 1 part.

The ulcerating surface is touched with a brush wet with the solution. If the surface is very uneven, the application is preceded by curetting. The solution is claimed to be not only very active in its effects, but inoffensive; it

modifies the march of the disease in a powerful manner, but does not influence detrimentally the neighboring healthy tissues.

After the carbolic acid has been painted on, the sore can be dressed with salol, but cicatrization will be obtained just as well by simply applying a little absorbent cotton soaked in a weak solution of alcohol or in aromatic wine.

Usually one cauterization is sufficient; in large chancroids the acid should be applied several days in succession.

If phimosis exists the brush should be introduced under the prepuce or a small quantity of the carbolic solution may be injected. During the day injections between the gland and the prepuce of a four-per-cent solution of resorcin should be made, or Labarraque's solution, etc., can be used.

GEORGE T. ELLIOT.

Chronic Enlargement of the Testicle. CHRISTOPHER HEATH, F.R.C.S. (*The Lancet*, Jan. 10th, 1891.)

It is as well to examine the vas deferens first. If this is found enlarged notice whether it is continuously so from above or below. If from above and leading down to an enlarged epididymis, the etiology is pretty obvious—pre-existing gonorrhoea, urethral stricture or some urethral irritation as the starting-point of the descending inflammation. In such cases treat at once the cause; put the urethra in a healthy state. If chronic enlargement persists, strapping, with mercury locally or systematically, may be necessary; still this is an innocent condition. Very different is that where we find the cord much thickened, and find on tracing it down that the epididymis is evidently the primary seat of disease. Such a condition generally pertains to tubercle of the testis. This disease appears in the epididymis and tends to spread in two directions—upward along the vas deferens and forward to the body of the testicle. The author thinks the disease intra-tubular—not inter-tubular—in origin and dissemination because of its rapid advance in opposite directions. When a patient is found to have distinct knots in his epididymis, these early manifestations of tuberculous disease may yet, under favorable conditions, be led to clear up and undergo absorption, but only under the most favorable circumstances—a long sea voyage in a well-appointed sailing vessel. If this is not admissible the best thing is to remove the testicle. If this be opposed, cut down upon the nodules and scoop them out most thoroughly. In the case of a patient with more advanced tubercular disease of the testicle, relief measures must be more radical, or where, again, the disease has already traversed the vas deferens, invading the vesiculæ seminales, prostate, and vesical neck, conservatism may be the kindest treatment.

It is only comparatively recently that the two forms of syphilitic orchitis have been recognized—the secondary and the tertiary. The secondary form is one of the later manifestations of this stage of syphilis, so that as his early eruption has disappeared, he may notice both testicles are beginning to enlarge; possibly one may antedate the other, but it is common to find both enlarged. The enlargement is very general. It clearly begins in the testis, gradually obscuring the epididymis completely as the enlargement advances. You find the cord healthy. The disease is entirely confined to the body of the testicle, and not infrequently is complicated by small hydrocele.

These cases are remarkable for having completely lost that peculiar testicular feeling, as it is called, which is characteristic of the healthy organ.

Some of these patients, however, although they have no testicular sense, have a great deal of tenderness about the testicles, with a feeling of weight or dragging.

Although in some cases the functions of these organs may be beyond repair because of permanent fibrous tissue organized from inflammatory deposit, leading ultimately to atrophy, still there are no more satisfactory cases for treatment than these purely syphilitic testicles. You may be sure that you will cure your patient—that is to say, you will bring the testicle down to about its normal size. The use of mercury alone or combined with iodide of potassium is to be advocated, not the latter alone.

It is important to distinguish this syphilitic testicular enlargement from that of new growth, viz., sarcoma. A youngish man may come before you with a large testicle.

It is not always easy to be sure which disease it is. A good deal will depend upon the history. If you are in doubt it is better, unless the tumor is growing rapidly, thereby showing its malignant nature, to give the patient a course of mercury. But given a rapid-growing tumor of the testicle, the sooner you remove it the better; whether sarcoma or carcinoma, it should be taken out.

In the later stages of syphilis we find the gummatous deposit particularly prone to appear in organs and parts which are vascular. The testicle is commonly the seat of syphilitic gummata. As a rather late sequela in syphilis it is not rare in old men, but you may have it quite at the other extreme of life—in children.

A syphilitic child will sometimes develop a gumma in the testicle which is apt to be mistaken for malignant disease. The tendency of gumma of the testicle is to break down.

Sarcoma of the testicle occurs as made up of round or spindle celled elements, generally mixed, although one kind of cell preponderates. They are tumors of rapid growth, and very commonly cystic formations are associated with the disease. When the diagnosis of sarcoma is clear, the testicle cannot be removed too soon. F. TILDEN BROWN.

Reinfection of Syphilis.

The important, interesting, and still open question of a second infection with syphilis is made prominent at this time by Dr. Taylor's report of two cases in this JOURNAL of December, 1890. Lubarski reports a case in the *Medicin. Rundschau*, 1890, of a soldier who in 1878 presented himself with a chancre which had appeared three weeks after coitus. Secondary symptoms appeared, and a course of forty inunctions was made. The following year there were later manifestations, which likewise disappeared under treatment. In 1880 there were tertiary lesions, and then came a period of eight years of entire freedom from symptoms. In December, 1888, a soft chancre appeared upon the prepuce a few days after exposure, and was followed by a suppurating bubo. This chancroid appeared to pass into an initial lesion of syphilis. In March, 1889 (three months later), there was a roseola, accompanied by angina, enlargement of the glands, etc. Treatment was carried out by means of injections of corrosive sublimate, gm. 2.0, in oil of vaselin, gm. 60, of which a Pravaz syringeful was injected once a week. (This case does not appear absolutely conclusive, for we know that in a syphilitic subject induration may occur in an incidental lesion, such as a chancroid, causing it to re-

semble a primary sore, and a roseola and angina resembling that of secondary syphilis may appear from other causes.)

The case which Harrison Young reports, on the other hand, in the *British Medical Journal*, No. 22, November, 1889, possesses more of the requisite features to make out a strong case. Here, after an infection in 1882, with symptoms showing themselves up to 1885 and an interval of four years of freedom, a new hard chancre was contracted in 1889, accompanied by indolent adenopathy and followed by roseola, mucous patches, etc.

Ducrey's case, reported in the *Giornale Italiano delle Malattie Ven. e della Pelle*, December, 1888, concerned a woman who gave a good history of syphilis, with characteristic secondary manifestations, adenopathy, etc. After marriage patient remained well for ten years. Then the husband contracted a chancre and infected his wife. When examined she was found to have a cicatricial induration of one of the labia, general glandular enlargement, a macular syphilide over the whole body, mucous patches on the soft palate and velum, and complained of rheumatic pains. At the same time there was such evidence of her former infection as a characteristic gumma of the scalp and multiple cicatrices of an old tuberculo-ulcerative syphilide, and atrophic scars from more recent dry tubercles. Other secondary manifestations of the reinfection followed; the body became covered with a small pustular syphilide, osteocopic pains became very severe, and an iritis developed, together with ulceration of mucous patches, etc.

This case seems to fulfil the conditions regarded by Fournier as necessary to establish reinfection, *i.e.*, characteristic secondary signs (initial lesion not noted in this case, though the late lesions seem to prove the first infection), a period of entire freedom from manifestations, a new indurated sore after coitus with a recently-infected husband showing secondary signs, and a renewal of secondary accidents.

Pospeloff (*Rev. de Cien. Med. de Barcelona*, 1890) relates the case of a patient who acquired a chancre two weeks after coitus in October, 1882. The nature of the ulcer was agreed upon by four physicians. In January there was fever and a roseola. Mercurial frictions were made. Mucous patches of the throat and lips then appeared and local treatment was instituted. In March, 1883, all signs of syphilis disappeared after mercurial frictions, but in May psoriasis palmaris was noted. At the end of October (one year after infection) inguinal adenopathy alone was noted. In 1884 treatment was continued and no signs of syphilis were seen. In 1886 patient married, and the event was followed by the birth of a healthy child. In December of 1889, four weeks after impure coitus, there appeared at the root of the penis and extending upon the pubis two lesions, which Pospeloff saw in the following February and diagnosed as true chancres. Six weeks later there appeared roseola, inguinal and cubital adenopathy, erythematous angina, and patches on the tonsils. The roseola disappeared after two months. Contrary to the views of Ricord and Sigmund, the second infection was more intense than the first. Two months after the roseola had disappeared there was some induration remaining at the site of the chancre; lenticular papules were disseminated over the internal surface of the forearms and thorax, and there were erosive papules on the lips. The observer considers these signs of syphilis in its second stage conclusive evidence of a reinfection, whose occurrence proves the cure of the first attack.

Dr. Clatworthy relates of syphilis recurring within three years of a first

attack (*Australian Med. Gaz.*, Feb., 1891). The first chancre appeared in January, 1888, leaving a scar and being followed by secondary symptoms, enlarged glands, mucous patches, and alopecia, but no eruption. Rheumatic pains lasted for a year. Mercury and iodide were taken for two years. In November, 1890, patient was again exposed, and in December a circular chancre was found near the site of the first, indurated and ulcerated; no accompanying glandular enlargements. A few days after the chancre had disappeared a well-marked macular eruption came out over the chest, buttocks, and thighs, and this was followed by bone pains and sore throat. The first attack was not personally observed by the reporter, and some elements of a strong case are lacking. CHARLES W. ALLEN.

The Applicability of the Electro-Urethroscope. DR. OBERLÄNDER. (*Internat. Centralb. f. d. Physiolog. und Patholog. d. Harn- und Sexual-Organe, Bd.* II., *Hft.* 5, 1890.)

Dr. Oberländer emphasizes the fact that long practice and careful study are necessary to become proficient in the use of the urethroscope. He states that when one has become skilled in the technique of the instrument cystoscopy presents far fewer difficulties than examination of the diseased urethra with the electro-urethroscope. To decide the question whether a gonorrhœa has been permanently cured, we must place most weight upon the clinical symptoms, owing to the difficulty of demonstrating the cocci in chronic cases. The clinical phenomena of importance in this connection are:

1. The changes of the mucous membrane, demonstrable with the urethroscope.

2. Microscopic examination of the secretions or mucous filaments, which have an etiological connection with the existing lesions. Attention should be paid to the presence of gonococci, although it is an unfortunate fact that they are absent in at least one-third to two-thirds of all chronic cases.

The urethroscopic examination is of chief importance in this affection, for in a large number of cases of chronic gonorrhœa the secretion has long ceased and filaments are only rarely observed in the urine. On the other hand, in all cases where a secretion is still present the disease can invariably be demonstrated with the urethroscope.

The previous studies in urethroscopy have been of little advantage to the general medical public, owing to the inapplicability of the instruments then in use and the consequent absence of correct anatomico-pathological observation. With the author's urethroscope, however, we are able to overcome all these difficulties and observe distinctly the pathological conditions present in the urethra. It enables us to demonstrate the color of the mucous membrane, the character of the epithelium, the presence of swelling of the mucosa and of cicatrices, glands, ulcers, etc. All these conditions can be readily made out by the skilled and careful observer, and to a certain extent even by the beginner. The experienced observer has of course the advantage of being able to combine the sum total of all he has seen into a diagnosis, and this is the part of urethroscopy which requires most patience and practice, although the results it furnishes are positive and clear.

The phenomenon which first presents itself to the observer is the changed color of the diseased mucous membrane, compared to that of the surrounding healthy parts. The normal color of the urethral mucous membrane varies,

according to the amount of blood contained therein, from a vivid or paler rose-red to a red or grayish-yellow hue. The diseased mucosa may be of a brighter color—*i.e.*, brighter red to dark bluish-red—or it may be paler in color than the surrounding parts and then usually present other striking features of the disease. Sometimes we see a dense network of diseased and dilated blood-vessels, the finest ramifications of which can be recognized.

In the second place, the urethroscopist should direct his attention to the condition of the normal longitudinal striation and longitudinal folding of the mucous membrane, since this is more or less changed or rendered invisible in all the inflammatory affections. The normal urethra in most parts of the pendulous portion has a distinct longitudinal striation and folding. In the frequently-occurring follicular dry inflammation (urethritis follicularis sicca) the longitudinal folding is usually entirely obliterated, while in consequence of some inflammatory infiltrations the longitudinal striation may be more sharply defined in some places. In cases of hypertrophic inflammation of Littré's glands (urethritis glandularis hypertrophica) the longitudinal striation becomes invisible; the longitudinal folding, however, often remains present, although changed to a certain extent. While in the normal urethra from eight to twelve folds can be recognized at the base of the cystoscope, the folds are thickened in the above cases and reduced to two, three, or four in number. Aside from these conditions, the surface of the mucous membrane should be examined for the purpose of seeing whether its lustre is increased or diminished, whether the epithelium is intact, whether there are visible gland openings, and whether exudations, secretions, swellings, etc., are present.

All these points must be cleared up in every urethroscopic examination, and the information thus afforded will indicate the degree and extent of congestion, the degree of infiltration, and the other pathological conditions of the diseased part.

The examination of the entire urethral canal is best done in sections. To examine the part extending from the point of junction of the anterior and posterior urethra to the external meatus, the instrument, provided with an obturator, is introduced as far as the commencement of the posterior urethra, and the examination made during its withdrawal. In endoscopy of the posterior canal a straight silver tube armed with a Charrier obturator is used.

We distinguish in the main two forms of chronic inflammation of the urethra:

I. Slight infiltrations which consist of small foci of fine granular matter. The inflammatory process frequently takes place in the upper layers of the mucous membrane and does not invade the submucous tissues. This form is termed by the author urethritis mucosa. The mucous membrane may be swollen, resembling red silk, soft, bleeding readily, or the swelling is less marked, less red, and the membrane is covered here and there with patches resembling epithelial desquamation and granulation, like soft formations.

II. More marked infiltrations and inflammatory forms, varying in extent to the most pronounced degrees of stricture, belong to this class. This is characterized, among other things, by the fact that there is from the beginning an intense and deep-seated tendency to inflammation. The fine granular infiltration soon becomes converted into stricture tissue. The in-

flammation involves always the entire mucosa, and the corpus cavernosum is either affected or displaced by the inflammatory exudation. The urethral mucous glands always participate in the inflammatory process, and hence the author has designated this form glandular infiltrative form of inflammation. The glands are either hypertrophied in groups (urethritis glandularis hypertrophica) or they are in a condition of follicular swelling (urethritis follicularis).

By means of the urethroscope we are able not only to diagnose the nature and extent of the disease, but also to demonstrate the progress toward a cure. The experienced observer is able at once to positively decide the question where the gonorrhœa may be regarded as cured, and this cannot be accomplished by any other method. F. TILDEN BROWN.

Treatment of Enuresis. W. E. STEAVENSON, M.D., M.R.C.P. (*The Lancet*, Jan. 10th, 1891.)

The author agrees with Kupke that one cause of enuresis lies in "diminished activity of the vesico-spinal centre in the lumbar part of the cord or partial anæsthesia of the sensory nerves of the bladder, both of these conditions preventing prompt information being conveyed to the cortex of the cerebrum when the bladder is becoming full." The complaint is not confined to children. It is a frequent complaint in young women, but the causes mentioned by the author for the trouble in women all point directly to an acute or chronic local functional or mechanical disability, and in no sense an impairment of vesico-spinal centre or sensory nerves of the bladder.

The author does not remember any of these cases which have failed to be cured by electricity. The author's method is guided by the law that the tendency of an electrical current, the resistance being equal, is to take the shortest route to complete the circuit. Consequently in cases where there is weakness of the sphincter, unless the positive electrode is placed in the urethra itself, it is placed on the perineum, while the negative electrode in the form of a wide pad is placed over the lower dorsal region. "Very weak" currents of the constant current are used every or alternate days. If galvanism fails the interrupted current is used. F. TILDEN BROWN.

Removal of the Third Lobe of the Prostate. Complete Restoration of the Function of the Bladder. FESSENDEN N. OTIS, M.D. (*International Centralbl. f. d. Physiolog. und Patholog. der Harn- und Sexual-Organe*, Bd. II., Heft 5, 1890.)

The patient, 52 years of age, had suffered since 12 years from desire of urination. Two years ago he observed considerable diminution in the size of the stream of urine and pains during micturition. A stricture was diagnosed and internal urethrotomy performed, but the operation effected no improvement in his condition. His urine became purulent, the pains at the close of micturition increased in severity, and after several months the patient began to suffer greatly from vesical tenesmus. An examination of the bladder revealed a concretion, which was removed by litholapaxy. No permanent improvement, however, ensued, and the cystitis persisted in spite of the use of the catheter and injection of various antiseptics, the pains in urination increased, while any degree of exertion produced violent vesical spasms. The urine was involuntarily voided, requiring the use of a urinal day and night.

The patient was examined for the first time by Dr. Otis on October 16th, 1889. The urine was strongly ammoniacal and contained much mucus and pus. A microscopical examination revealed many pus-cells and bacteria, but no renal elements or albumin. Bimanual examination per rectum and abdomen showed no enlargement of the prostate nor any other abnormal conditions, and careful examination of the bladder with a Thompson's sound failed to detect a calculus. He was ordered to empty his bladder at regular intervals and to use antiseptic injections; and under this treatment the vesical symptoms and character of the urine were improved, the residual urine being diminished during the following month from 16 to 8 ounces. Subsequent soundings for stone also gave negative results, but with the Leiter's cystoscope a dark spot of the size of a ten-cent piece could be observed at the left side of the fundus of the bladder. At the end of the cystoscope a slight induration was demonstrable, which appeared to be either an encysted calculus or a new growth of the vesical wall.

An exploratory operation seemed indicated and perineal section was performed on November 22d. On introducing the finger into the bladder a marked enlargement of the third lobe of the prostate was made out, which protruded above in form of a firm tumor into the interior of the organ. This measured an inch in breadth and thickness. A small soft mass was also found which was detached from the vesical wall with the exercise of only slight force. Assisted by the finger in the rectum, the larger mass was forced through the perineal opening and proved to be a calculus of the size of an almond. A forceps was then introduced and a shred of mucous membrane was removed, together with a large coagulum. It was evident that the stone had been encysted, and had been held in situ by a thin layer of mucous membrane. Owing to the patient's debilitated condition it was decided to postpone excision of the third prostatic lobe until it could be observed to what degree the vesical symptoms were alleviated by removal of the calculus. The wound healed without complication of any kind, and after fourteen days the patient was again able to walk about. The vesical tenesmus, however, soon returned, and the cystitis, which had somewhat improved, again increased in severity. It now became manifest that the main disturbances were caused by the enlarged third lobe, and an operation for its removal was undertaken on January 17th, 1890. After the performance of suprapubic cystotomy a finger was introduced into the bladder and detected an encysted calculus at the posterior vesical wall, which was found to be a phosphatic concretion of the size of a small almond. The vesical wound was then dilated and the cavity examined with the electric light. Aside from the chronic cystitis nothing abnormal was found except the enlargement of the third lobe of the prostate, which was situated just at the internal orifice of the urethra. Perineal section was now performed, and a short écraseur introduced through the wound into the bladder. With the aid of the cystoscope inserted through the supra-pubic opening, the wire could be accurately adjusted around the base of the tumor and the latter completely excised. The remaining stump was smooth and on the same level with the surrounding tissues. Slight hemorrhage followed the operation, which was soon arrested by tamponing the bladder with iodoform gauze. The bladder wound was not sutured. Notwithstanding careful drainage and frequent change of dressings, it was found difficult to keep the patient dry on account of the large quantities of urine discharged. It was found impossible to secure

efficient drainage through the perineal opening. Recovery was unimpeded except by an attack of pleurisy with effusion induced by the patient catching cold. This complication caused much debility, and for two weeks the patient was in a precarious condition. During this time the supra-pubic wound, which had been rapidly healing, opened again, but had completely closed eight weeks after operation. The perineal wound was kept open in order that the bladder might regain as much as possible of its tonicity. The quantity of urine gradually diminished, while the specific gravity was increased, and at the end of March the patient was discharging 45 ounces on the average of a sp. gr. of 1,015. At this time the perineal wound had nearly closed and he was passing his water per vias naturales, about 3 or 4 ounces of residual urine being left in the bladder, but this quantity gradually decreased. At the beginning of April the perineal wound had closed and the patient could completely empty his bladder. When last seen he was freed completely from all his former symptoms.

F. TILDEN BROWN.

Items.

Treatment of Non-Syphilitic Vegetations of the External Genital Organs. *Gazette de Gynécologie*, February 15th, 1891.—According to Tchernomordik, the best treatment for conylomata acuminata is Bockhart's caustic lead prepared as follows :

℞ Oxide of lead, ... 0.25 c.
Sol. caustic potash, 33%, ...50 c.
M.

The vegetations should be bathed with a disinfectant and thoroughly dried. They are then painted with this mixture by means of a pledget of cotton wrapped around a small rod or stick. At the end of five minutes they become black and are transformed into a mass of mucous consistence which is easily wiped away with the cotton. The slight resulting wound may be powdered with iodoform.

Where the vegetations are quite voluminous they must be treated two or three times with the caustic lead, which may be done in a single sitting unless the growths are too numerous. In the latter case it may be necessary to make a number of applications at intervals of two or three days.

These cauterizations being but slightly painful, cocaine may be dispensed with in a majority of cases.

According to Caro Urriola (*La Semaine Médicale*), the preferable treatment for vegetations of the external genitals is the following combination :

℞ Acidi salicylici, ... 2 grams.
Acidi acetici, ... 30 grams.
M.

The vegetations are painted with this liquid two or three times in the twenty-four hours. Two or three applications usually suffice to cause the vegetations to disappear. The pain is insignificant and of short duration.

A most excellent formula (Morrow, "Venereal Memoranda") for both condylomata lata and acuminata is the following powder :

℞ Acidi salicylici, ... gr. x.
Acidi boracici, ... gr. xxx.
Calomel, ... ʒ i.
M.

Dust freely two or three times daily. Under its influence the condylomata rapidly melt away.

Treatment of Sycosis. *Annales de Dermatol. and de Syphilig.*—Rosenthal recommends the following method, which possesses the advantages of facility of application, freedom from pain, and relatively rapid cure.

The diseased surfaces should be carefully shaven each day and the following ointment applied two or three times a day:

℞	Tannic acid,	1 gm.
	Sulphur,	2 gm.
	Vaselin,	10 gm.

M.

After the friction with this ointment at night, an emollient ointment, Wilson's or Hebra's, may be applied.

The writer has also recently employed with good results the following paste:

℞	Tannic acid,	5 gm.
	Sulphur,	10 gm.
	Oxide of zinc,	
	Starch,	āā 17–50 c.cm.
	Vaselin,	50 c.cm.

M.

This may be applied night and morning. By this method epilation may be dispensed with.

Absorption of Medicaments in the Form of Ointments. *Rep. de Phar.; Jour. de Méd. de Paris.*—Luff concludes as a result of numerous experiments that active medicaments administered in the form of ointments are best absorbed when vaselin is the excipient. Lanolin is the best excipient when a local action is desired, since the medicaments will not be absorbed. Experiments were made with iodide of potassium, phenic acid, and resorcin mixed with vaselin, lard, and lanolin; the mixture was placed in a sheep's bladder, plunged in a vessel of water maintained at a constant temperature of thirty-six degrees. The water was examined at short intervals to detect the medicaments. The exosmosis began in the iodide of potassium mixture with vaselin after one hour, with lard after nine hours, with lanolin not at all. The phenic acid mixture with vaselin after two and a half hours, with lard after seven hours, with lanolin not at all. In the resorcin mixture with vaselin after ten hours, with lard after fifteen hours, with lanolin not at all. The ointments prepared with lanolin presented no reaction after twenty-four hours.

Ergotin in Gonorrhœa. *Viadernosei Lekarski; Jour. de Méd. de Paris.*—Roicki regards ergotin as an excellent agent in the rapid cure of chronic gonorrhœa. He gives it both internally and as an injection after the following formula:

℞	Ergotin,	.30 centigr.
	Distilled water,	300 gm.

M.

Several injections daily. The injections are well supported.

Salicylate of Mercury in Gonorrhœa. (*A. G. Silbermintz.*)

℞	Salicylate of mercury,	.20 centigr.
	Distilled water,	180 gm.
	Gum arabic, q.s. to make an emulsion.	

S.

Shake well and inject three times a day.

DR. MUIRHEAD'S CASE OF HEMORRHAGIC EXANTHEM FOLLOWING INFLUENZA

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Original Communications.

A PECULIAR EXANTHEM FOLLOWING AN ATTACK OF EPIDEMIC INFLUENZA. (WITH CHROMOLITHOGRAPH.)

BY W. L. MUNRO, M.D.,
Providence, R. I.

MY patient was Mary D——, 25 years old, single, domestic, native of Prince Edward Island.

Father and mother died of phthisis; one brother still living and in good health.

Patient well nourished and robust. Previous history good, with the exception of an attack of amenorrhœa, four years ago, lasting six months and rendering her an invalid for six months more.

Perfectly well, recently, until December 26th, when she had a moderately severe attack of epidemic influenza, characterized by cephalalgia and pleurodynia at the outset, with general malaise, anorexia, etc., for the first two days. The appetite then returned, but diarrhœa set in, lasting a week.

At the end of a week, *i.e.*, January 3d, all symptoms had disappeared except a short, dry, hacking cough. Appetite excellent, digestion perfect, bowels regular. During all of this time she had received no medical attention.

January 23d, twenty days later, some cough still remaining, she "got her feet wet and took a fresh cold." Next day she was attacked by cephalalgia and otalgia, with stiffness of the neck. For three days, during the continuance of the otalgia, there was almost complete anorexia and insomnia. No vomiting or distress at stomach, bowels regular. The day after wetting feet she began also to have frequent attacks of epistaxis, and, on blowing nose, blew out much bloody matter.

January 28th. Discharge of thin laudable pus from ear, subsidence of otalgia and cephalalgia, return of appetite, so that, to use her own expression, "she enjoyed eating." No gastric disturbance, bowels regular.

Patient, however, had severe pains in joints of extremities, most marked in knees and shoulders; wished to lie down all of the time, felt sleepy, and "more dead than alive."

January 31st. Noticed an eruption on the skin. Sent for me for the first time.

When seen, discharge from ear had almost ceased, considerable œdema of hands, forearms, feet and ankles; eruption on arms, particularly forearms, and on legs and knees. This eruption was macular, non-elevated, varied in size from a silver three-cent piece to a half-dollar, dark, dull-red in color, permanent on pressure, very sore to the touch, accompanied by considerable infiltration beneath the skin.

Subjective symptoms limited, in her words, to "a dull, sore ache;" no itching or burning. Pulse and temperature both slightly elevated. Marked general malaise, soreness over whole surface of body.

February 2d, two days later, spots more numerous and average somewhat larger. They retain the same general characters as a whole, but some spots, in addition to the livid discoloration, begin to show a hemorrhagic centre, these hemorrhages tending, in the smaller spots, to assume a cruciform shape, in the larger a reticulated appearance, the meshes showing tissue of the same livid character as the rest of the patch. Patches still non elevated, seated on infiltrated bases, very sore to the touch. One large spot, possibly two and one-half inches in diameter, on left forearm just below the bend of the elbow, showing all of these characteristics especially well marked, the criss-cross lines of hemorrhage having a width of perhaps one-twentieth of an inch. Uvula, soft palate, pharynx, tonsil, etc., all show similar hemorrhages beneath the mucous membrane. Digestive functions fairly well performed. Still weak, languid, and unwilling to move, but talked quite cheerfully when seen. Joint-pains so marked that she needed help in displaying the eruption.

The lower limbs showed none of the hemorrhagic spots, but, both here and on the arms, many of the earliest appearing macules were undergoing involution, giving rise to numerous shades of green, yellow, etc., according to the stage of the eruption.

Treatment was now changed, patient being given:

Tr. ferri chloridi,
Ext. ergotæ fl., ... āā ℥ xx. t. i. d.
and Quin. sulph., ... gr. ij. 4 i. d.

February 4th. Same general characters obtained, but spots are more numerous on upper extremities, and have appeared in numbers on the face. Œdema of arms and face marked, being sufficient in the loose tissues of the lids to close the eyes. Spots on the face are mostly small, but hemorrhages are seen in many of them. Hands and fingers covered with spots, many of large size, and much swollen; *one immense patch* on surface of left upper arm.

This patch was most marked, extending almost from shoulder to elbow. The islands of livid tissue were variously shaped and ranged from the size of a pea to that of a cent. The interlacing network, of what appeared like greatly-distended lymph-spaces, was filled with dark, bloody serum, like that of a blood-blister, being in places so full as to distend the epidermis, making a mesh-work of canals more or less filled with fluid, at some points feeling like collapsed soft tubes, at other points raised above the surface, like long and narrow blebs.

For two days past has been obliged to pass water with great frequency, but urine has not been scalding nor micturition painful. It was high-colored, but contained no blood.

On this day the patient first complained of moderate itching, limited to spots which were undergoing involution.

February 5th. Seen during the day, with a view to diagnosis, by Drs. Mitchell and Gardner.

Depression less, feels much better; no new spots for twenty-four hours. Yellowish and greenish hues now very general. Eyes partly open. Spot on left forearm now fading, but that on left upper arm at its height. Symmetrical spots on the two breasts, that on the left being a simple macule, that on the right being a beautifully-marked example of the peculiar hemorrhagic form. Trunk otherwise clear.

February 6th. No new spots; all are undergoing involution. In the larger spots some of the hemorrhagic channels are still filled with dark, bloody matter, while most of them now present a sunken and depressed dull-white appearance. Mild itching, not enough to call for scratching, over the affected surfaces.

February 8th. Improving. Spots of a dingy-grayish hue in most instances. Œdema mostly gone. The larger hemorrhagic spots are still plainly seen, and somewhat sensitive to the touch, though rapidly clearing up. Long canals, partly filled with bloody serum, still seen. The fluid in these can be passed along by the finger from one place to another so as to distend the portion apparently empty. In some points the epidermis between these canals is loose and can be raised up. Appearance of these larger spots is now that of greenish-yellow macules, intersected and divided up by a dark-red network.

May 10th, three months later, patient called at office. Perfectly

well. At the site of patch on the upper arm and on the right breast, a discolored surface is still seen, intersected by grayish lines, representing the obliterated canals.

December 1st. Nothing left to determine the location of the patch on the arm. On the right breast a faintly rosy spot about the size of a two-cent piece is still visible.

As regards diagnosis:

The case is unique in its manifestations, and unlike anything which I have been able to find on record. Neither of the gentlemen who saw it with me could identify it with anything they had seen or knew by description.

We have a constitutional disease occurring in a robust, well-nourished subject and characterized by malaise, languor, loss of strength, severe joint pains and soreness of the flesh, some gastric disturbance, though slight, and the peculiar manifestations in skin and mucous membranes which I have detailed above.

These subjective symptoms, together with the earlier eruption, as a whole, and the eruption upon the lower extremities throughout its course, at once suggested *purpura hemorrhagica*, the so-called *land scurvy* of some writers. The course of the disease was essentially that of a mild case of hemorrhagic purpura, resulting in recovery.

The lesions of mucous membrane were just what we should expect in a robust, young subject, suffering from purpura of moderate severity. At no time was the blood so impaired as to occasion those debilitating hemorrhages so often met with in advanced cases.

The lesions of the skin could readily be divided into two classes. Of these, the first, seen especially upon the lower extremities, but also in numbers upon the arms and face, differed in no wise from the typical eruption of purpura hemorrhagica. In their progress toward resolution, also, these macules followed a typical course, exhibiting, as they gradually disappeared, the various shades of color so often seen in extravasations while undergoing absorption. Mingled with them upon the arms and face were the peculiar lesions which gave to the case, as a whole, its unique, and somewhat startling appearance.

Are we justified in considering these as an unusual and hitherto unobserved form of the same eruption, or must we look upon them as due to some intercurrent disease?

In considering this question we must bear in mind the great diversity in the lesions of hemorrhagic purpura according as it appears in a strong, young subject, or in a broken-down and debilitated old, or prematurely aged, person. It is from this latter class that by far the most cases arise, and it is from our observation of them that the picture of the disease, present to our mind's eye, is drawn.

Duhring says: "According to the amount of blood extravasated and the permeability of the tissues, will the spots be small or large, circumscribed or diffused, roundish or irregular in shape, and otherwise peculiar."[1]

The patient in this case was a healthy, young adult, with unusually fine muscular development for a woman. It is fair to suppose that the connective-tissue element of the skin was abundant and dense. Such being supposed to be the case, it requires no forced deduction to assume that blood extravasated in very moderate amounts into the corium, and following the direction of "least resistance," would occupy and distend certain of the larger lymphatics of the derma, pushing aside the connective-tissue bundles and giving rise to the appearance of canals and canaliculæ of bloody serum.

The almost complete absence of eruption upon the trunk was a noticeable feature in this case. It is not unusual in purpura for the lesions to affect particularly the extremities; and this accords with the theory which finds the origin of the disease in "disturbances of vascular innervation dependent upon diminished action of the vaso-motor centres."[2] Such vaso motor changes would, as a rule, be most marked in the extremities.

Without going into the question of differential diagnosis, suffice it to say that no other described disease of the skin accounts equally well for the various lesions seen in this subject, and hence, notwithstanding its variance from accepted types. I am disinclined to seek a new origin, a new explanation for the case under consideration, but look upon it as one more of the many neuroses observed as following epidemic influenza, though occurring in this unique form of purpura hemorrhagica, or land-scurvy.

THE OCULAR AND TACTILE DEMONSTRATION OF URETHRAL LESIONS BY THE AID OF NEW INSTRUMENTS—SHOWN WITH CASES.[3]

F. TILDEN BROWN, A.M., M.D.

IN the presence of such an invention as the cystoscope, with its recent added refinement which permits even of the probing if not catheterization of the ureter, it seems like presumption to present tools for inspection of the urethra. For, to those not practised

[1] Duhring: "Diseases of the Skin," p. 364.

[2] Renaud and Cornil; Duhring: "Diseases of the Skin," 363.

[3] Read before the Section in Genito-Urinary Surgery of the New York Academy of Medicine, March 12th, 1891.

in these pursuits, it must appear that if the bladder is capable of illumination and visual exploration, certainly the "approach" to such a remote viscus, because of its comparative superficiality, must be, not only easier of examination by sight, but that many of the various devices for effecting this examination must ere this be perfectly satisfactory.

To even a greater extent may it be regarded as presumption by those who have devised these already successful instruments, and by others who have learned to use them.

For these reasons I am led to ask your condescension for bringing before you a new effort in a long since old and already accomplished undertaking. If I shall attempt to-night to excite anew an interest in the subject of urethral examination, it must be because I believe these particular instruments afford an opportunity for its better, quicker, and easier accomplishment.

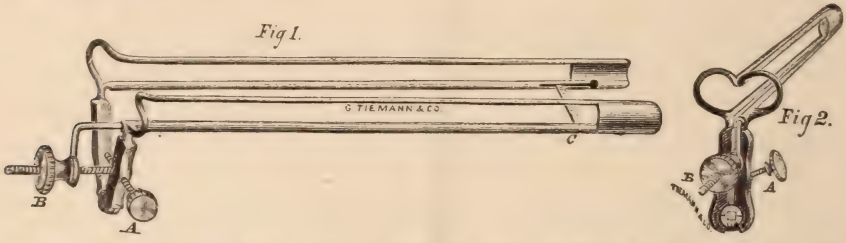


FIG. 1.—THE AUTHOR'S WIRE URETHRAL SPECULUM OPEN. C, The lever for spreading the vesical end which is governed by the right-angled rod attached to the travelling screw button B; A, the screw which spreads the base or meatus part of the speculum.

FIG. 2.—THE AUTHOR'S WIRE URETHAL SPECULUM CLOSED. Shows the small square aperture in the binding screw for the attachment of the illuminator, Fig. 3.

How much this belief is due to personal prejudice or to the more prolonged experience with my own instruments to the exclusion of other forms, must be left for you to determine from to-night's demonstration with the speculum and its accessories of the different lesions and normal conditions of the urethra.

Before passing around the instruments with the manikin of penis and urethra, let me show upon this living subject of granular urethritis, the method of introducing the speculum closed (Fig. 2), then the ease of painlessly distending the urethral walls by operating the screws A and B (Fig. 1), where screw B controls the opening lever C near the tip of the speculum, while screw A has a similar control in spreading the base of the instrument. The canal is now in condition to render one advantage of the speculum appreciable in that, not only is there a full exposure of mucous surface at its vesical end—the only purpose aimed at by the endoscopic tube—but, in addition to this, there is shown a continuous expanse of urethral surface along the four

walls, from base to tip of the instrument. This exposure seems to me to be a valuable accession in visual examination because by it the canal can be viewed as a whole in contra-distinction from piece-work. Here the contrast between the appearance of healthy and abnormal mucous surface is the first indication in determining the location and extent of disease. It is acquired without any movement of the speculum. If the source of trouble is seen to exist on the walls in the anterior two inches, its immediate although oblique visual inspection is quite satisfying; if, however, this focus is seen to be deeper than two inches, then the urethral mirror (Fig. 5) must be resorted to for giving the satisfactory details of the pathological conditions. By the mediation of this mirror, which acts exactly as the laryngeal mirror, we have the means of deflecting the illumination upon the mucus surface and of receiving a clear right-angled visual image in return.

Finally, if the sense of touch is to be called upon to verify or elucidate that of sight, whether to determine the tension and extent of stricture tissue, or to test the sensitiveness of an inflamed or ulcerated lesion, the urethral digit (Fig. 7), with its probe tip extended, is passed down the speculum, directed by the eye to the desired spot: then the movable probe tip is flexed at will against this spot by operating the thumb screw at its handle. By the use of this device, slight inflammatory infiltrations, the earliest deposits of ultimate strictures, can be readily detected in the following way: Pass the digit to the bottom of the distended canal, flex its probe tip, and bearing gently with this upon the tense mucous membrane, bring the digit forward with guarded and moderate rapidity. It will be felt to hobble over any of the infiltrations even when they are too insignificant to render the slightest impediment to the bulbous bougie. Visual examination with the speculum reveals a slight bulging of the mucous membrane always surrounding these little deposits, in part, perhaps, from œdema, but principally from mechanical reasons governing the conditions of scar and circumscar tissue in general, when rendered tense. But these slight and often non-inflammatory (in appearance) lesions thus revealed between the bars of the speculum I did not comprehend until, by use of the tactile method just spoken of, the infiltration hidden in their centre was always appreciable and explanatory. A condition somewhat resembling this in its reaction to the digit, but exaggerated, is to be found after incomplete urethrotomy, or more commonly to ineffectual gradual dilatation, after the operation, where either little bands of tissue escaped division or, if divided thoroughly, union was afterward effected here and there by neglect during the granulating stage of healing. In the two urethral manikins which I now pass for examination (one by the speculum, the other by the endoscopic tube) I have made the artificial

lesions as much alike as possible; in each can be seen a rough reproduction of the pathological state presented by the several living subjects here to-night; the demonstration on whom, however, must be deferred until the close of the paper.

With your first casual comparison of tube and speculum you will be impressed, I think, first, with the greater ease of inserting the latter, and when opened, with the greater size and better exposure of the urethra at the vesical end; but especially noticeable is the total expanse of mucous membrane seen at once from meatus downward; whereas, the gradual withdrawal of the endoscopic tube to gain a view of successive small fields, while effective, is, at the same time, much less satisfactory.

The manikins represent: At five and one half inches a hypertrophic granular urethritis of the bulb.

At three and one-half inches, almost wholly confined to the roof of the urethra, a papillomatous condition interspersed with short, tense, fibrous infiltrations.

Between three and two inches normal, smooth, gray-yellow mucous membrane.

At two inches a resilient ring stricture seen stretched as a yellow-white cord across the bars of the speculum and readily felt by the digit as a band on each wall of the urethra. This is an elastic rubber ring, stitched in place outside of the kid urethra; it reproduces well the condition in the living urethra already spoken of, namely, that of bulging inward of the membrane immediately anterior and posterior to the stricture itself.

At one and one-half inches a deep reddish oval ulceration with ragged precipitous edges and an inflammatory zone surrounding it; into this the probe digit, when drawn along the urethra, sinks and tends to hold. In the living subject of this lesion instant and sharp pain is elicited by this contact.

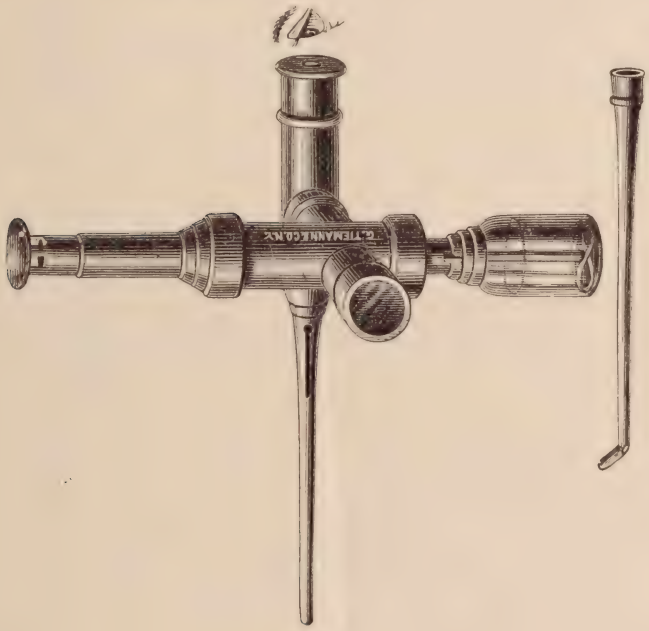
At one inch is another resilient ring stricture.

At three-quarters and one-half inch are three superficial mucous erosions represented by increase of color and loss of epithelium, the œdematous membrane at their margins is of paler color than that in the centres, and that just beyond. These are the lesions which in micturition are often sensitive upon the first impact of urine, and they, as well as the ulceration, may be spots of hyperæsthesia independent of the urinary act.

Up to the present date the available methods of examining the urethra by sight are mainly included in a review of this subject given in connection with his admirable monograph on blennorrhœa by Dr. E. Finger of Vienna.

Since I have, through the courtesy of Dr. Fordyce and of Messrs. Stohlmann and Pfarre, been able to collect all of these instruments mentioned by Finger, besides a few not devised at the time of his publication, I have thought that a hasty presentation of each would not be without interest in connection with my subject. As the kind and method of illumination employed is of vital importance, whatever the medium of exposing the urethra may be, this should receive more than the passing allusion which our time will only now allow.

This is the endoscope of Désormeaux (Cut A), by the instrumentality of which, as long ago as 1855, he prepared an essay upon its ap-



Cut A.

plication to diagnosis and treatment of affections of the genito-urinary passages, wherein is produced so complete a pathology of urethral disease that we cannot fail to admire both the intellectual qualities and the manual dexterity which, used in conjunction with this ponderous weapon, indifferently lighted, gained for the inventor and his essay a division of the Argenteuil Prize of the Imperial Academy of Medicine. In his treatise upon the use of his instrument he speaks of gazogene, a mixture of alcohol and turpentine, as affording the best flame for the illumination. This flame is intense and small.

Imagine the specialist of to-day approaching his patient with this eight-pounder!

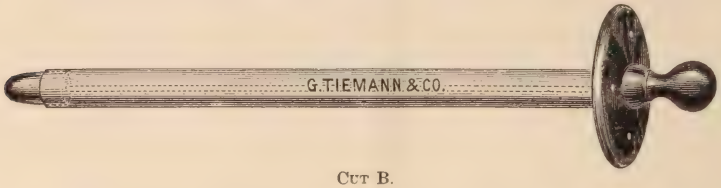
I may here state that Désormeaux, in calling attention to his endoscope, announces that he was not the first to attempt vesical and urethral examination by sight. He outlines the work of M. Ségalas, Fresnel, Every, and Ag. Haeken of Riga in this direction.

In fact it is safe to believe that the idea of visual inspection of bladder and urethra is as old as the history of surgical contrivances. It only took practical shape, however, when first Fresnel remarked to Ségalas that by placing the light on one side and by means of an inclined mirror which reflected the concentrated rays in accordance with the axis of the tube he would succeed in getting illumination without, at the same time, intercepting the line of vision.

Next Hacken employed the component parts of Désormeaux's apparatus, viz., tube, reflector, and light, separately.

Gruenfeld employed the concave head mirror in conjunction with long tubes with deep funnel ocular end.

Steurer's modification of the latter's tubes resulted in shortening them to permit of better illumination, and telescoping of the urethra



CUT B.

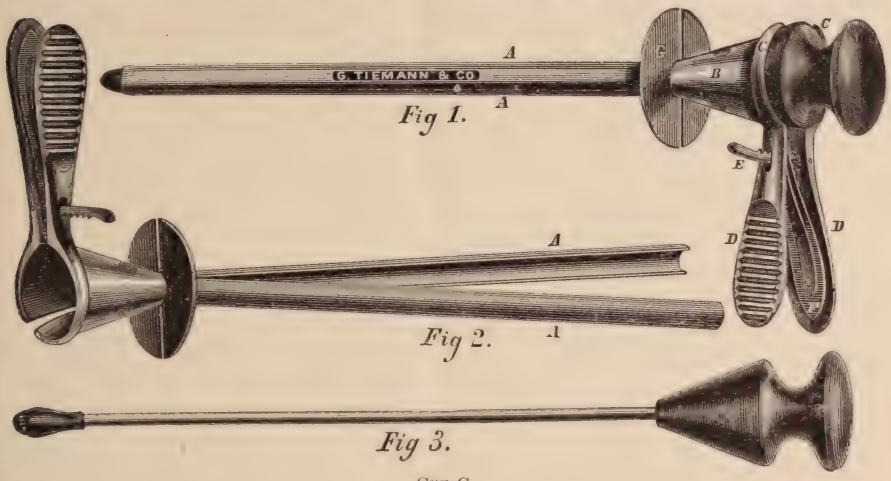
upon the tube was resorted to for reaching its deeper parts. The tubes were also less painful to the sensitive meatus by the adoption of a disk-hilt just in front of the Gruenfeld funnel.

Klotz, of New York, has modified Steurer's tubes by dispensing altogether with the funnel ocular end (Cut B). These tubes are here more generally used than any other.

This is Auspitz's (Cut C) bivalve endoscope which, over its obturator, is to be introduced closed. Its special purpose is to distend the mucous surface at the vesical end of the instrument, while it does not disturb or distend the meatus. In great part the instrument defeats its very purpose, for, by being undilatable at the base it lacks the necessary aperture for the accession of sufficient light to illumine the much larger field at the other end.

Von Antal introduced the aero-urethroscope for the double purpose of gaining, in the first place, a continuous exposure of urethral surface and of obviating, in the second place, any infringement upon the lumen of the canal as must necessarily be the result whenever any tube, however thin, is passed into the urethra. I am not able to show

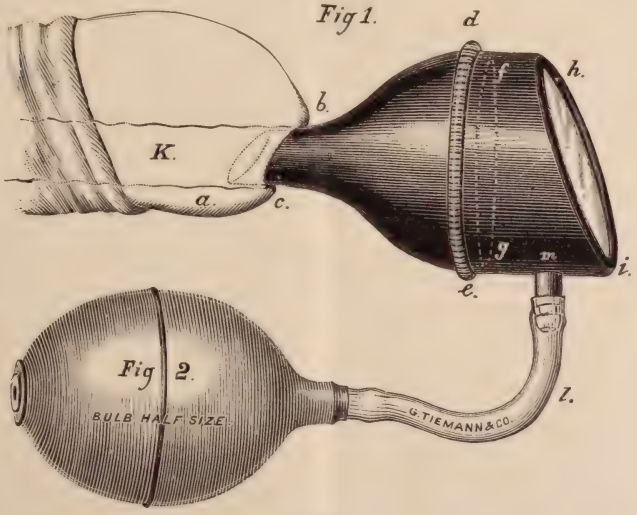
you Antal's instrument, but this later device of Heuer's (Cut D) is very similar; they both resemble in many respects a Siegel's otoscope, notwithstanding the fact that the former is an air-tight attachment for



Cut C.

inflation, while the latter is intended for producing a vacuum, or at least aerial depletion.

Antal's device is of use only in the straight part of the canal.



Cut D.

Finger intimates that what it gains by exposing a greater mucous area is in great part lost for diagnostic purposes because this tissue is always artificially anæmic from pressure of the air. Of course this

instrument precludes all possibility of tactile investigation or topical treatment while it is in place.

This beautiful and elaborate mechanism of Oberländer's belongs to Dr. Fordyce,[1] to whose paper I will refer you for a full English description of the apparatus.

Suffice it now to point out only its unique features. First, the situation of the illuminating, white-hot platinum loop is novel, in being placed at the vesical end of the endoscopic tube. It is carried down the tube by this delicate rectangular rod which, in addition to the electric wires, contains also an afferent and efferent tubelet for cold water, upon the perfect circulation of which the urethra must depend for protection from over heat.

The inventor's pathological studies with this device have been among the most important contributions since the work of Désormeaux. Never having had the opportunity to see the working and the possibilities of Oberländer's instrument, I cannot speak from experience. Finger criticises the illumination because so placed as to be too intense; he dislikes also the infringement upon the lumen of the main tube by the electric and water staff, and again he considers the necessary attention to battery and water supply as too diverting to the examiner.

This Leiter electro-endoscope, where *reflected* electric light is used, goes back to the Désormeaux principle, both in regard to illuminating the canal by reflected rays and in having the tubes attachable to the hand light; in other words, it is compact and, when in use, all in one piece. Finger considers this the most practical and serviceable instrument for endoscopy. The tubes for this instrument are much like those of Steurer and Klotz.

For some time I have been using this hand illuminator of Leiter's in conjunction with my speculum. For examination alone it is excellent, but in treatment, or where both hands are needed for other purposes, it must yield to a skeleton modification of it which I here show you. It is that of Dr. W. K. Otis, of this city.

As this is something quite new I must not anticipate the inventor's satisfaction in its personal introduction. You see, it is much less cumbersome than the Leiter instrument, and can have its own weight supported by the short endoscopic tube when in the urethra. This is a most important advantage, as it gives the examiner both his hands.

I have devised, but not yet had made, a modification of Otis's illu-

[1] JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, Jan., 1889.

minator, for ready attachment to my speculum (Fig. 3). I have suggested to the makers, G. Tiemann & Co., that this be made of aluminium, thereby reducing very materially the weight of even Otis's instrument. The sliding of *m* upon the rectangular bar *g*, will also be an improvement, as it permits nicer focusing of the all important central and most parallel rays from the mirror. According as to whether the speculum of two and a half or six inches in length is used the vesical-end-focusing may beneficially be altered to suit either of these extremes in length or any of the intermediate forms. As Hacken departed from the device of Désormeaux in separating the latter's illuminator, reflector, and tube, so have I broken up, as it were,

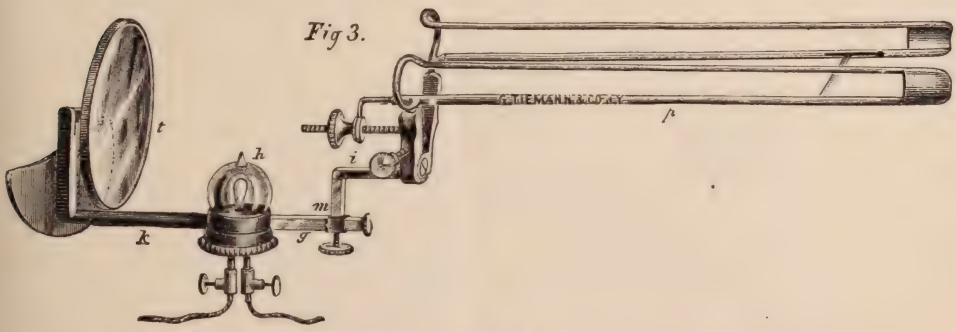


FIG. 3.—THE AUTHOR'S MODIFICATION OF THE W. K. OTIS ELECTRIC ILLUMINATOR. As attached to the speculum.

the component parts of the Leiter apparatus, the electric illumination, the mirror, and I may add also the tube, except that I substituted the speculum for the tube.

Fig. 8 represents an arm of two rods, each five inches long, articulated with four universal ball-socket joints. At its distal end an electric light with lens condenser. At the proximal end the whole arm swings freely from the top of a metal post attached to the table. (A shows a cock switch for turning on and off the illuminating current. The light is swung to a position about parallel with the penis. The rays are then reflected from the head mirror into the open urethra through the speculum

The patient reclines on a rather high, short table, his legs slightly separated are pendent from the knees, the examiner standing between the knees.

For the time being I am so well satisfied with all the details of this mode of urethral inspection that I feel perfect confidence in commending it to any who may have some such purpose in mind.

It probably requires greater practice to gain the same results by using the three parts of this mechanism detached than when all

are in one, but when this ability is once acquired there are many minor advantages to recommend it.

In order to complete a little more fully this subject of visual inspection of the urethra I am justified in showing you Freudenthal's modification of Voltolini's electric apparatus for transillumination of the larynx; it fits quite well to the convexity of the penis, and when the urethra is evenly distended with the wire seculum you can look down the urethra and imagine some such origin for the term "paint-

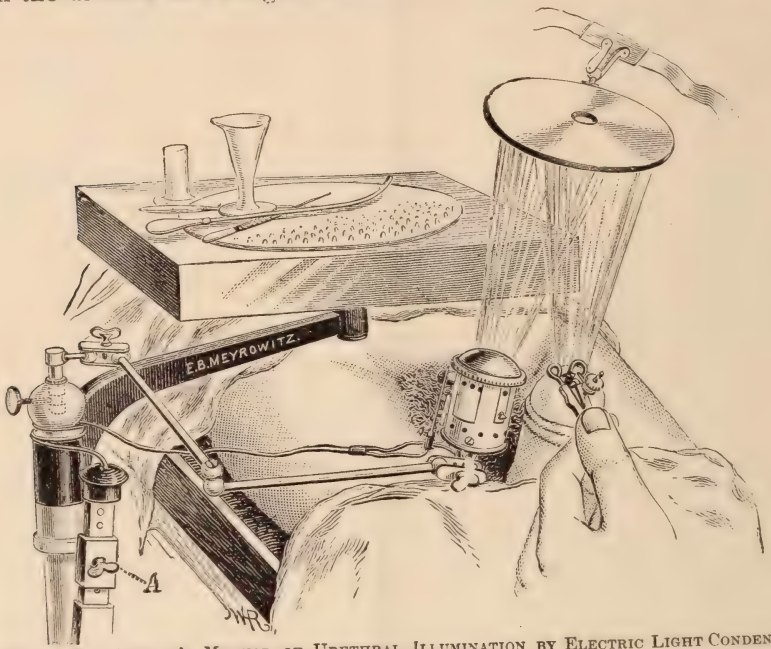


FIG. 8.—THE AUTHOR'S METHOD OF URETHRAL ILLUMINATION BY ELECTRIC LIGHT CONDENSER, Parallel with Penis, on an Adjustable Arm Which Swings from the Top of Metal Part Attached to Table. Head Mirror is Shown Reflecting the Light Through the Speculum into Urethra. *A*, Cock for Opening and Closing Urethral Current.

ing the town red." Everything is red as far as you can see and in every direction through the tissues. According to my brief experience with this light it is about as limited in usefulness in urethral exploration as Roth and Gottstein represent it to be in laryngeal practice.

The only evidence of disease which I have been able to detect with it was where stricture tissue was dense enough to modify the color at these particular spots to a dark red in contrast with the prevailing rose-red tint. This contrast was most clearly shown when stricture affected a limited patch along the floor of the urethra, as in this locality the tissues intervening between the light and the open urethra are so much thinner than those which surround the side walls

and roof of the urethra. The increased density of these fibrinous infiltrations of course effects the increased opacity which results in different shades of red.

In part, and under different forms, this urethral speculum has been described and illustrated in the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES for May, 1888, and March, 1889. It was shown, with other instruments, at the last meeting of the American Association of Genito-Urinary Surgeons. Since you can now see and test its construction I will only call your attention to a single special feature: namely, that both ends of this speculum are independent of each other; they are under separate control by the screws A and B, Fig. 1. The arms may remain closed at the tip while they are opened at the base, or vice-versa. This extreme convergence of the arms at either end implies, of course, the possibility of spreading both base and tip alike, or to any degree between parallelism and obliquity which the

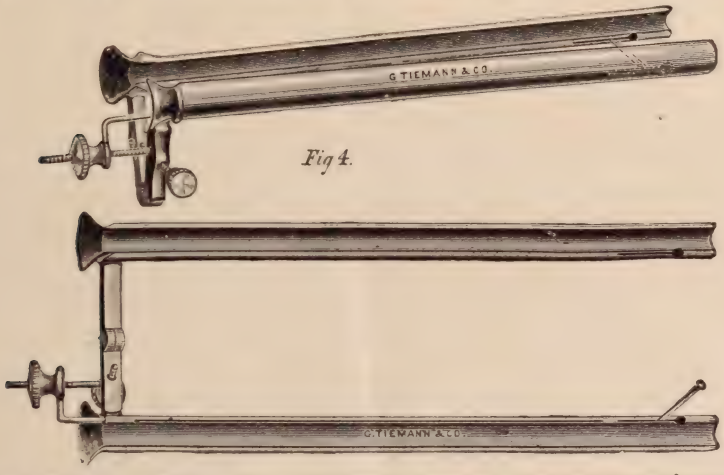


Fig 4.

FIG. 4.—THE AUTHOR'S SOLID BI-VALVE URETHRAL SPECULUM. The lower figure shows the full extent to which all these specula open for easy cleansing.

conditions of that particular urethra will permit. These specula vary in size from two and a half to six inches in length, and from eighteen millimetres to twenty-eight millimetres in circumference when closed. Lest it may not be understood why, when the small speculum of eighteen millimetres circumference closed is capable of spreading so as to fill the largest urethra, it is still advantageous to have others of greater closed circumference, I will call your attention to the fact that the distance between the two lateral bars of each arm is always the same irrespective of the distance to which these arms are opened. Hence the small speculum spread in a large urethra would give only a long transverse slit-like opening.

The solid bivalve speculum (Fig. 4) is of course used exclusively for examination of the urethra as it collapses over the vesical end of the tube. This solid, or semi-solid form of speculum is essential generally in parts deeper than the bulb, because when entering and beyond the subpubic curve the mucous membrane of the convexity would bulge between the upper bars of the wire speculum, thus shutting out the parts beyond from vision.

When a single speculum is wished, I recommend that of four inches length and twenty-two millimetres closed circumference.

The urethral mirror (Fig. 5) is entirely metal; the highly polished

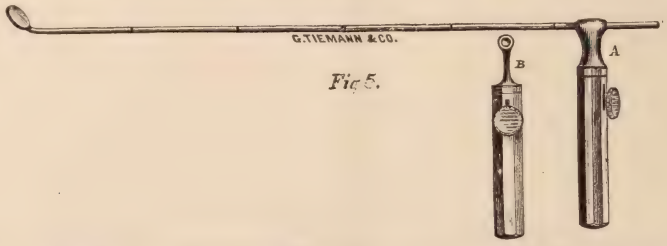


Fig 5.

FIG. 5.—THE AUTHOR'S URETHRAL MIRROR WITH SELF-ADJUSTING SPRING HANDLE.

reflecting disc correspond in sizes to the French measurements, 18, 20, and 22. The rods have inch marks by the aid of which, with the sliding and revolving handle, one can the more readily determine the exact depth of lesions. The little thumb-button governs the spring brake which holds the rod firmly when released. By this play of the mirror staff in its handle any of the four walls can be examined while the handle is held in one position relative to the penis. The mirror is slightly warmed in a spirit flame or brushed with glycerin before introduction to prevent condensation.

Fig 7.

FIG. 7.—THE AUTHOR'S STRAIGHT 6-INCH URETHRAL DIGIT. C, The movable probe-tip controlled by U-spring and thumb-screw at handle. Inch marks are indicated along the upper rod.

The urethral digit (Fig. 7) is a sort of delicate probe six inches long with a movable blunt tip; this tip is extended by a U-spring which makes a ring handle to the instrument intended for the first phalanx of the middle finger. To flex the probe tip turn screw x with index finger and thumb of the same hand. Independent of the speculum this urethral digit is often of a good deal of service in an initial examination to test the general existing conditions of the urethra. With it, the existence of coarctations, whether close or of large calibre, can be readily appreciated, as well as the presence and exact locality of

erosions and hyperæsthesic spots. My original purpose for the instrument was to determine upon *which face of the urethra any particular stricture predominated.* Information of this sort cannot, of course, be acquired with bulbous bougies.

In this connection I may mention the result of my observations, regarding the most common locality for early and moderate stricture deposit, without being prepared to offer any explanation. I have found these early and slight infiltrations much more commonly along the roof of the urethra than along the floor; the lateral walls are less frequently affected than the roof, but more often than the floor. I incline to the belief that this ratio holds good in the more extensive forms of deposit as well. If these assumptions may be proven, they will afford an additional reason for the prevailing practice of incising strictures in the median line along the urethral roof. As having some relation to this subject I will state what might be reasonably

Fig 6.

FIG. 6.—THE AUTHOR'S LONG CURVED URETHRAL DIGIT. A, Movable probe-tip for upper segment of posterior urethra; B, movable probe-tip for under segment of posterior urethra.

inferred, namely, that ulcerative patches and erosions, as exposed by the wire speculum, have this same most common localization on the upper arc.

Besides the six-inch straight digit, I exhibit two of eight inches (Fig. 6) with pubic curve. A has its probe tip flexed upward, for exploration of the upper segment of the prostatic and membranous urethra, while B flexes downward to bear upon the lower segment. These two are not very commonly used or of much value, for the presence of the movable tip in the posterior urethra is generally resented by so much involuntary spasm as to nullify the value of all tactile inferences.

It is safe to assert that since the time when Désormeaux published the results of his endoscopic studies specialists have been well aware of the importance of visual inspections and localized treatment in diseases of the urinary tract—a fact so forcibly attested to by this collection of instruments, where in each an attempt has evidently been made to correct or overcome some inadequacy of the other, that it

would be superfluous for me to attempt to emphasize this universal recognition.

Yet to-day, even among specialists, what percentage of urethral cases receives this ocular examination, acknowledged to be so valuable? Certainly a smaller proportion than there should be, and why? Because experts have taught that initial employment of the endoscope, even in chronic cases, is not well tolerated; it may prove injurious. Therefore less irritating methods of diagnosis and treatment take its place; the sound, the bulbous bougie, or the urethrometer are first used. If with these an approximate determination of existing conditions is arrived at, treatment is apt to be begun and continued without the intervention of endoscopy.

A second reason which is responsible for the too exceptional employment of sight in these complaints is time; not so much the time spent in acquiring the dexterity incidental to its application, but when this dexterity is acquired the time necessary for a carefully conducted and satisfactory examination with the endoscope is a matter of much importance to the busy surgeon, who instinctively thinks of the advisability of introducing the tube; but the succeeding thought of how little the endoscope will reveal to him at each step as the instrument very slowly advances from bulb to meatus, this, coupled with the number of patients in waiting, leads to a mental postponement until the next visit when, perhaps, the same excuse is just as urgent.

So I think it is just to affirm that the majority of practitioners will refrain from endoscopic examination until thoroughly satisfied that the disease is not getting well as rapidly as it should, or, having once or twice been apparently cured, the trouble relapses without adequate cause.

While I do not mean to criticise this conservative practice if it is true that the early use of the endoscopic tube is attended with ill results, I wish, at the same time, to call attention to the fact that the easier insertion of the speculum, and with it the less painful and more extensive exposure of the urethra, affords us a means for earlier active interference, with the greater assurance of immunity from those irritating effects which are said to attend endoscopy under similar conditions. For, after distending the urethral walls and their examination, the speculum is, if necessary, collapsed before withdrawing it.

In connection with the limitations incidental to the use of the endoscopic tube I would like to quote the following from an article[1] by Dr. W. K. Otis: "In spite of the many and decided advances made in the urethroscope, its use has never been very general, nor is it ever likely

[1] "Recent Improvements in Urethroscopic Apparatus," **N. Y. Medical Journal**, April 13th, 1889.

to become so. In the treatment of gleet by the urethroscope the spots of granulation are easily observable and easily medicated, and frequently disappear under use of the applications. But they almost inevitably lie behind strictures, are dependent for their existence upon this fact, may be almost as definitely located with the bougie-à-boule as with the urethroscope, and are quite sure to return, sooner or later, unless the existing cause is removed. As regards the diagnosis of stricture, for which purpose some authorities have given this instrument great credit, it is without value.

"We judge a urethra is strictured simply because the tube will not pass some point in the canal; it gives no more information as to the calibre of the stricture, the extent of the stricture, its resiliency, or the existence of other contractions below it, than can be obtained by the use of the obturator alone.

"False passages may occasionally be observed and avoided by its use. Foreign bodies, impacted stone, etc., are often more easily removed by this than by any other means. It is valuable in the detection and treatment of urethral chancroids and invaluable in the removal of urethral neoplasms. But its successful use requires considerable technical skill, and a knowledge of the slight differences exhibited by pathological conditions of the urethral mucous membrane, only obtainable by long, careful and patient study, so that in spite of the very great improvements recently made in the urethroscope it will probably continue to remain, for the most part, an instrument for the specialist alone."

In evidence of what this author says regarding the slight differences exhibited by pathological conditions when shown by the tube, I pass you, Mr. Chairman, these recent and excellent photographs of small urethral discs, taken by Arthur Kollman, of Leipzig.

With the exceptional employment and exceptional utility of the endoscope, as expressed by Otis, let me contrast the much more general applicability of the urethral speculum. I trust the manikin demonstrations have already done much to make the claim evident, and that you are already prepared to appreciate, since your tests through the speculum with digit and mirror, that many of the limitations attaching to the urethroscope do not hold good of the speculum, as instance the strictures, rendered tense across the speculum, demonstrable to sight by the mirror and nicely defined by touch with the digit. At the same time instance the fact that these strictures are advantageously exposed for incision, under the guidance of the eye, when there is no risk of needlessly cutting normal mucous membrane immediately adjoining these infiltrations.

I trust, also, that you are none the less prepared to appreciate that all

of the advantages claimed for endoscopy, as carried out with the tube, are enhanced in endoscopy with the speculum, as instance the increased facilities for the removal of a neoplasm or a foreign body through its open sides or its vesical extremity easily adjustable at any part. Instance also the facilities for making applications of an anæsthetic or mild astringent to the entire tract by pouring such a solution into the distended urethra, or again the facilities for making strong topical applications to only isolated lesions whenever seen along the canal, as granulations in the bulb and erosions near the meatus. But I am speaking to-night on the use of the speculum in diagnosis only. The time properly allotted for one of several papers at our evening meetings makes this a necessity. I will only say here that its possibilities in treatment are in no way secondary to its service as a diagnostic medium, for while acting in this latter capacity the speculum can be made to fulfil the indications and assume the functions ordinarily relegated to the sound. In a word, you are often inspecting and treating your patient at the same time with one instrument. Consequently, with me, this instrument has assumed a very important rôle, almost wholly supplanting two which have long been the main reliance in urethral practice, namely, the sound and the bougie.

Except in cases of disease in the prostatic and membranous urethra, I no longer use the sound or bougie-à-boule; this holds good as regards both diagnosis and treatment, providing the canal is large enough to accept the smallest speculum. I find that the closed speculum can be introduced and gradually opened without local anæsthesia, to a greater extent with very much less pain than if I had attempted to pass a sound at once, the circumference of which is two or three sizes smaller than the distention given with the speculum.

In my urethral practice the use of the speculum, instead of being exceptional, has rather become the rule. To me, genito-urinary work without this instrument would become as much curtailed, not only of its interest, but I believe of my ability to advantageously serve my patients, as would be the case if the gynæcologist were deprived of his speculum, to him a diagnostic aid of secondary importance to digital exploration, which to us is never available.

It is because of its more exclusive pursuit of all the details pertaining to genito-urinary practice that this section of the Academy has asked and been granted recognition as an independent branch of the surgical tree, and it is because I have full confidence in your individual interest concerning the smallest twigs of this branch that I have had the assurance to so minutely call your attention to these urethral devices.

ON CHRONIC PROSTATITIS.

By DR. OBERLAENDER,
Dresden.

OF the chronic inflammations of the prostate that which is the most frequent and the most known is the so-called old man's hypertrophy. Whether it rightly bears this name, how it originates, and what symptoms are produced by it, are questions which I have not the intention to discuss. There are still other, for the most part little known, forms of chronic prostatitis which do not come in the late years of life, which last a long time, and leave behind a host of troublesome symptoms whose origin the practising physician often does not seek where the seat of the trouble is to be found. As already mentioned, men in the best years of life become affected with this disease. They may have suffered from gonorrhœa for a longer or shorter time, but this is also in at least half the instances not the case, and we have then in such instances to regard as etiological factors continued excesses in venere et Baccho, masturbation, etc. A decided predisposition to catarrh of the mucous membranes, especially that of the urino-genital canal, appears also to play a decided rôle. This is a fact which was a long time ago pointed out to me, and one which I have very often spoken of at length; that the disposition to chronic and severe disease of the urino-genital system is pre-eminently one of the individual, and one which, indeed, is not without a certain hereditary influence in many cases, as, for instance, has already been long established in the so-called old man's hypertrophy of the prostate.

In speaking of excesses, I must turn the attention to *coitus reservatus* or *interruptus*, which when in excess and long continued, belongs to the most harmful practices of sexual life which exist. This is capable, in whatever way practised—and I cannot here particularize—to call forth and for years to keep up all possible, severe as well as slight, nervous disturbances in the urino-genital system, and in the general nervous system, without the cause being discovered or known by the physician. The local annoyance caused by this chronic prostatitis is often slight, some burning on passing water, especially after excess of diet, occasionally increased urgency to urinate, but frequently these patients suffer from a very disagreeable nervous weakness of sexual power. The erections in this condition may be increased, or diminished. At the critical moment they are, at any rate, either too weak or not present at all. Often too *ejaculatio præcipitata* takes place and after cohabitation there is great bodily and mental exhaustion.

Very often the patients complain only of the latter and a host of other nervous symptoms. If only at the same time even slight abnormality in the region of the genitals is admitted, one should never neglect a local examination. In the urine are to be found for the most part more or less striking mucous threads, which microscopically are seen to consist of epithelium, prostatic bodies, spermatozoa, and small particles of strongly-refractive detritus.

The prostate examined *per anum* is usually more or less irregularly enlarged. As a rule, only one lobe is affected and can be felt to be soft and uneven. The swelling is seldom or never hard. Here and there are also separate painful points, which when they appear, cause the patient to complain of a painful feeling of pressure in the rectum, in the perineum, as well as of a painful twitching after coitus and after pollutions. More rarely can we succeed, by pressing upon the gland, in causing a drop of prostatic fluid to escape by the urethra. This under the microscope shows prostatic bodies, and, by the addition of one-per-cent solution of ammonium phosphate, sperma crystals.

By means of the urethroscope one can always make out decided disease of the posterior urethra, often in its whole extent, at times though only the prostatic part, especially the region of the colliculus seminalis.

The mucous membrane is here either of a decidedly red color, bleeding very easily, soft and covered with soft granulation-like and also papillomatous growths, or on the surface it is smooth, and on passing the tube over it becomes yellowish-white and shiny, showing that here, through preceding chronic inflammation, abnormal distribution of blood is present.

The first form is by far the more amenable to treatment. The patients, like all those who suffer in their sexual organs, are for the most part depressed by their disease, which they bear secretly for a long time before they go to a physician. The disturbance of their sexual power, the painful sensations after cohabitation, and the indefinitely painful discomfort which manifests itself in the genital region in the most developed cases after every effort, and every error of diet and which can increase to torturing pain, all have at length an enervating influence upon the sufferers.

To overcome the general nervous disturbances we can, with benefit, send the patient to one of the well-conducted institutions, or a rest in the mountains or at the sea shore will do as much if not more for them. A careful course of local treatment, carried out at the same time or previous to the patients' being sent away, will often of itself prove sufficient.

We must see to it that the patient has proper nourishment and

regular movement of the bowels. An empty rectum is a pre-requisite condition to the well-being of all these patients. We accomplish this in the most comfortable way by means of a clyster or a mild cathartic. Camomile or valerian clysters, to be retained, as well as camomile tea and sitz-baths, are always found very efficacious in allaying the pains.

For the feeling of pressure in the rectum, from painful and enlarged prostate as well as from the sensitive urethra, I have for many years recommended and employed iodoform suppositories. Iodide of potassium suppositories are impracticable, and by far not so efficacious and usually of no value whatever. The iodoform should be taken up quickly in small quantities locally applied, *i.e.*, in the rectum. For this purpose the small amount of iodoform is dissolved in oil of sweet almonds. In this form the absorption is sure to take place. One can order:

℞ Iodoformi, ... 0.5–1.0
Solve in
Ol. amygdal. dulc., ... q. s.
Ut fiat solutio stabilis.
Butyri cacao, ... q. s.
Divide in suppositoria decem.

Before introducing the suppository a clearing-out clyster is to be given. To begin with, each evening before going to bed a mild suppository should be given. If this does not prove sufficiently active, the dose of iodoform can be increased from 0.075 to 0.1 gram pro suppositorium. Sensitive persons display undoubted intoxication symptoms after 0.1 gram of iodoform per rectum. The milder doses are borne without harm and act exceedingly well. We have in iodoform suppositories, after a few weeks or possibly days, a marked effect, while the iodide of potassium irritates the mucous membrane and must be interrupted for a long time. The urethra offers the principal point of attack in treatment, whence the unskilful operator can undoubtedly often do more harm than good.

One can use with care a one to two per cent solution of nitrate of silver to cauterize the posterior urethra, an entirely harmless manipulation when undertaken with the requisite precautions, which can be repeated once or twice a week. The introduction of large metallic sounds often acts well: also are good results to be obtained from the employment of the Winternitz psychrophor, especially in the subsequent relaxation of the muscles of the posterior urethral sheath. Bleeding is not infrequently present after the first applications of the cautery and the introduction of the larger bougies, and it has no significance so long as one knows his ground and is conscious of not

having wounded the normal canal. As a rule, it does not recur. Relapses belong in this disease to the regular occurrences—a condition of affairs which the patient makes worse by not putting much confidence in a cure.

The patient must be prepared beforehand for the possibility of relapses, and wherever possible before the onset of new symptoms, treatment should be again instituted. It is not in reality proper to reckon this among the incurable diseases. If it appears so to the physician, the ground for it must be sought in the lack of regimen in the patient's life, not to overlook the excesses in venere et in Baccho.

Those cases which have developed from a gonorrhœal base are the ones to get well the quickest and best. The worst cases are especially those in which the individual predisposition to catarrhs of the mucous membranes is present; also in patients who suffer from chronic intestinal, respiratory, and nasal catarrhs.

The above brief description of chronic inflammation of the prostate or often only an inflammation of the prostatic portion of the urethra and seminal vesicles, belongs to the class of genital neuroses, a full description of which I gave in part in No. 275 of Volkmann's Sammlung for the year 1886.

LUPUS VULGARIS, IN ITS RELATION TO TUBERCULOSIS.[1]

By JAS. C. McGUIRE, A.M., M.D.,
Washington City, D. C.

THERE is no question within the domain of dermatology that has occasioned greater controversy, or that has been more thoroughly investigated by the most competent observers, than the nature of lupus vulgaris.

Since Professor Koch introduced his fluid as a cure for tuberculosis, the whole question has been infused with new interest; it seems now to be the opinion of most medical men and an accepted fact, by medical as well as non-professional writers, that lupus and tuberculosis are identical in their nature. I propose in this paper to give a short resumé of the opinions on this subject of the more eminent dermatologists in this country and abroad, both from their published writings and in answer to questions I have addressed to them by letter. The arguments as to the relationship of the diseases to each other are based on the following questions: The clinical difference. The micro-

[1] Read before the Section of Dermatology at the meeting of the American Med. Associat., Washington City, May 6th, 1891.

organism that is said to be peculiar to both. The inoculability of the tuberculous tissue. The occurrence of lupus in tuberculous subjects. And the peculiar reaction occurring as the result of the injection of "tuberculin."

First, then, to consider the clinical difference, tuberculosis of the skin is a very rare condition. When it occurs, it is found almost exclusively upon the mucous membrane at first, only subsequently, if at all, extending to the skin; its progress is comparatively rapid. In lupus, we have a disease relatively frequent, usually found upon the skin at first, from which it may spread to the mucous membrane, slow in evolution and comparatively painless. Vidal and Leloir have pointed out abundant clinical evidence to show the essential difference between the two morbid processes. According to these observers, lupus of the throat may be considered indolent and painless, when compared to pharyngeal tuberculosis.

The tubercle bacilli were discovered by Dr. Robert Koch in the lung tissue of consumptives. Afterward, 1883, Demme demonstrated their presence in lupus. They are peculiar in being easily stained in colored anilin solutions that have been rendered alkaline, but it must be remembered there are other micro-organisms, which are so similar in appearance that they cannot be distinguished even by the most experienced bacteriologists, except for the fact that one is stained only in alkaline solutions, while the other, that of leprosy, may also be stained in neutral and acid solutions as well. Though Demme believed he had demonstrated the bacilli in lupus tissue in great numbers, and Doutrelepont, Pfeiffer, and Koch believed they had verified his discovery and so conclusively demonstrated the identity of the two diseases, yet there are not wanting those who declare, if the bacilli exist at all in lupus tissue, they are extremely rare.

Drs. Morison and Symington (*American Journal Med. Sciences*, 1884) examined the tissue from twenty lupus cases without result. M. Cornil (*Le Progrès Médical*, 1883) subjected sections of diseased skin from eleven lupus patients to microscopic examination; only one bacillus was found and this was evidently from a phthisical patient.

Even granting that the bacilli have been frequently found by later observers, yet the opponents to the theory of the unity of the two diseases declare this is no proof, for the bacilli should be found in every case if they stand in causative relation to the disease.

Dr. Tilbury Fox was one of the first to call attention to the fact that lupus showed a predilection for tuberculous subjects. Dr. Felix Block (JOURNAL CUTANEOUS AND VENEREAL DISEASES, March, 1887) reports 144 patients with lupus, in whom 114, that is, 79%, were affected with some form of tuberculosis. Sacks found only fifteen out of one

hundred and five cases. According to Besnier, eight of thirty-eight lupus patients had well-marked phthisical signs.

In reply to a question in my circular letters, the following answers were received: Dr. Piffard, New York: "If the patient lives long enough with the lupus uncured, he is pretty apt to die of phthisis.

Dr. Duhring, Philadelphia, does not believe there is any peculiar constitutional condition accompanying the disease. Dr. Duncan Bulkley, New York, is of the opinion that a large share of lupus patients exhibit other manifestations of tuberculosis. Those who believe in the unity of the two diseases explain the reason why general tuberculosis is rarely to be found with lupus as follows: "Lupus virus is for the organism a weaker and less dangerous noxa, on account of the quality of the organ in which it is localized;" "the localization of tuberculosis in the skin is a factor causing the relative harmlessness in this way, that the products of disintegration do not get into the circulation from the cutaneous investment in sufficient quantities to produce acute general tuberculosis, the process remaining local." (Prof. Neisser, Ziemssen's "Handbook of Skin Diseases"). As to the inoculability of lupus tissue, Conheim reports negative results, while Schüller and Hütter (Ziemssen's "Handbook of Skin Diseases") report successful positive experiments and, therefore, interpret both diseases as sequels of the same poison, only the noxa is weaker in lupus. Professor Schwimmer does not believe the disease can be produced by the inoculation of tuberculous tissue. Though Besnier declares that lupus is auto-inoculable, others believe that scarification may be performed without the least accident.

Professor Vidal (JOURNAL CUTANEOUS AND GENITO-URINARY DISEASES, September, 1887) is reported to have inoculated himself many times without result.

Of course we all know that Professor Koch regards the peculiar symptoms that follow the inoculation of his fluid as of great diagnostic importance. Ergo, as these symptoms follow the injection in lupus patients, it is proof positive of the presence of the tubercle bacilli, and, as a consequence, the identity of the two morbid processes is established; but if Koch's fluid has a curative effect upon lupus, does it necessarily follow the disease is due to the tubercle bacilli? This is one of the questions embraced in my circular letters; in thirteen replies, eight are in the negative, five in the affirmative. The five who believe in the diagnostic importance of the lymph are: Professor Bulkley, who says: "I should be inclined to think its effects in lupus an argument, if needed, that the disease was due to the tubercle bacillus."

Dr. Ravogli: "If Koch's fluid has such a remarkable action in

lupus we can come to the conclusion that the disease is due to the tubercle bacilli."

Dr. G. H. Fox: "From the use of Koch's lymph in four of my own cases, and observation of its use in several others, I believe it has a beneficial, if not curative effect in lupus. Its marked effect upon tuberculous disease and slight or no effect in other cases, would seem to support the belief that lupus is due to the tubercle bacillus."

Professor Keyes: "If Koch's lymph does cure tuberculosis, and also lupus, I think this is proof."

Dr. Graham: "If lupus can be cured by Koch's fluid it necessarily follows the disease is due to the presence of the tubercle bacilli and their products."

Of the eight who are opposed to these views, Professor Duhring says, "If lupus is relieved by Koch's fluid, it does not prove that the cutaneous lesions are due to the tubercle bacilli."

Professor White, of Harvard, declares "that late observations show that it is not inactive in some other diseases."

Dr. Jackson: "As Koch's lymph will produce reaction in some non-tuberculous diseases, the reaction produced by it in lupus is not positive evidence of the tubercular nature of the disease."

Dr. Wigglesworth's answer is, "By no means, tuberculin lays claim to parasitical qualities of a general nature."

Dr. McCall Anderson, Glasgow: "If lupus can be permanently cured by means of Koch's lymph, I do *not* think it necessarily follows that the disease is due to the tubercle bacilli, because other diseases have been proven to react under the inoculations."

Dr. Bowen: "The fact that the agent attacks leprous and other tissues besides tuberculous, makes it worthless as a means of differential diagnosis."

Dr. Pringle: "No, not necessarily, for the so-called lymph similarly stirs up other tissue, *e.g.*, leprosy."

Professor Kaposi, Vienna: "The prompt reaction of Koch's lymph in lupus does *not* prove by this fact alone that lupus is identical with tuberculosis; it proves only that the tissue of lupus belongs among the greatly vascularized and inflammatory tissues."

In the literature of the nature of lupus vulgaris, it will be found that, in 1862, Veiel expressed the opinion that it was one of the later manifestations of syphilis. At the same time Erasmus Wilson declared that inherited syphilis was the most frequent cause of the disease. In 1875, Piffard expressed the opinion which he still holds, that the disease is essentially a scrofulous affection. Herbert Stowers, Hardy, Bazin, Billroth, and others held the same opinion; on the other hand, Kaposi considered "the symptoms of scrofula in lupus patients, as

such symptoms occur so seldom, as of no importance." One of the most eminent opponents to the idea of the identity of lupus vulgaris and tuberculosis is Professor Vidal, of the Hospital St. Louis, Paris, than whom there is no more thorough and conscientious investigator, and but few have had such clinical experience; he is most emphatic in his denial of the unity of the two morbid processes. He lays particular stress upon the marked clinical difference between them. Professor Schwimmer (JOURNAL CUTANEOUS AND GENITO-URINARY DISEASES, September, 1887) questions whether the micro-organisms found in lupus are the same as those found in tuberculous tissue. He does not accept as fully proven that lupus is a tuberculosis of the skin. Dr. Hutchinson's (JOURNAL CUTANEOUS AND GENITO-URINARY DISEASES, February, 1889) inference is against any connection between the two diseases. According to Friedlander (Ziemssen's "Handbook of Skin Diseases") lupus is a local tuberculosis of the skin. Baumgarten believed the diseases should be kept apart, while Professor Neisser (Ziemssen's "Handbook of Skin Diseases") declares that lupus is one of the forms in which tuberculosis occurs in the skin, modified by the small quantity of active virus. Leloir (*Le Progrès Médical*, October 4th, 1884) affirms that it is as yet impossible to positively affirm that the diseases are identical.

M. Cornil (JOURNAL CUTANEOUS AND VENEREAL DISEASES, December, 1883) thinks lupus is sufficiently differentiated from tuberculosis by the slowness of its progress.

So much for the opinions of those whose writings I have consulted. It will be observed that but few authorities in this country have been quoted, as their writings, in but few cases, have been accessible to me. It was determined to address circular letters to the best-known dermatologists in this country and abroad for their views. It is my desire now to thank these gentlemen for their prompt and complete answers to my questions. As there is so much confusion in the literature of this subject, as many text-books do not even attempt to answer the questions, a synopsis of the replies to my letters may be of particular interest, especially as the views on this question of many of these eminent men cannot be obtained elsewhere.

"Is lupus vulgaris a manifestation of tuberculosis?" Out of twenty-five answers nineteen are in the affirmative, only six taking the opposite view. Of these six, Prof. Louis Duhring, of Philadelphia, says: 'Clinically lupus vulgaris and tuberculosis are not identical, and for purposes of diagnosis and study, for the present at least, I think they should be differentiated."

Dr. Ed. Wigglesworth's, Boston, answer is: "Not yet proven."

Dr. Lassar, Berlin, Germany: "Lupus vulgaris and tuberculosis

belong to the same clinical category; still they show some difference which tends to diagnose one from the other."

Dr. Earnest Schwimmer, Budapest: "Clinically, lupus must be distinguished from local tuberculosis, but I would not deny that the relationship between both diseases is very near. I do not regard lupus as a manifestation of tuberculosis."

Nineteen out of the twenty-five believe the two diseases are identical.

Prof. E. L. Keyes, New York: "There are many forms of tuberculosis. Lupus is one of them"

Dr. G. H. Fox, New York: "I regard lupus vulgaris as one form of tuberculosis of the skin."

Dr. G. T. Jackson, New York: "I suppose we must consider lupus vulgaris as a form of tuberculosis which, as a rule, is entirely localized."

Dr. P. A. Morrow, New York: "Etiologically yes" (they are identical).

Dr. A. Ravogli, Cincinnati: "When we find the bacillus tuberculosis in the tubercle of the lupus, we have no more doubt."

Dr. L. Duncan Bulkley, New York: "Clinically, lupus and tuberculosis cutis are very distinct, but both exhibit the tubercle bacilli. So far as disease processes caused by the same element are identical, they must so be considered, the clinical difference being due to the nidus where the bacillus locates itself."

Dr. John T. Bowen, Boston: "It seems to me that, with our present knowledge, we must regard lupus as a *form* of cutaneous tuberculosis."

Dr. G. H. Rohé, Baltimore: "I regard lupus vulgaris as a form of local tubercular infection."

Dr. Graham, Toronto: "In my opinion lupus is a manifestation of tuberculosis in the skin."

Dr. Hardaway, St. Louis: "The weight of evidence seems to favor the belief that lupus is a chronic tuberculosis."

Dr. G. H. Tilden, Boston: "Yes" (the diseases are identical).

Dr. Wm. T. Corlett, Cleveland: "Clinically, lupus vulgaris seems to bear no relationship to tuberculosis; neither is it common for lupus and tuberculosis to be present in the same individual. Histological appearances would lead me to infer, however, that they were closely related, if not different manifestations of the same disease."

Dr. H. G. Piffard, New York: "Lupus vulgaris is unquestionably tuberculosis of the skin."

Dr. Unna, Hamburg, Germany: "Lupus vulgaris is undoubtedly tuberculosis of the skin."

Dr. A. Weyl, Berlin, Germany: "The bacilli found in lupus seem to be identical with the bacilli found in tubercular growths of the inner part of the body."

Dr. J. J. Pringle, London, England: "I consider that there are three clinical types or expressions of skin tuberculosis with many intermediate connecting links. The most acute is acute tuberculosis of the skin, of which I have only seen one case, and of which but few are recorded; the subacute or intermediate type is represented by scrofuloderma, the chronic type, by lupus vulgaris."

Dr. T. McCall Anderson, Glasgow, Scotland: "I have always held that lupus is a manifestation of tuberculosis."

Dr. R. B. Morison, Baltimore: "Lupus vulgaris is a form of local tuberculosis, but differs clinically from an ordinary local tuberculous ulceration."

Dr. Ernest Besnier, Paris, France: "Lupus vulgaris is a form of cutaneous tuberculosis."

Both from the literature that has been accessible to me and from personal letters in answer to my questions, I am able to tabulate the following:

Those who believe in the identity of the two diseases: Koch, Demme, Pfeiffer, Doutrelepont, Friedlander, Tilbury Fox, Besnier, Neisser, Plumb, Hardy, Bazin, Pringle, Bowen, Tilden, Graham, Corlett, Keyes, McCall Anderson, Unna, Weyl, White, Hardaway, G. H. Fox, Rohé, Piffard, Jackson, Ravogli, Bulkley, Morison.

Those who do *not* believe the two diseases identical: Vidal, Leloir, Schwimmer, Veiel, Cornil, Wilson, Hutchinson, Lassar, Kaposi, Duhring, Sherwell, Wigglesworth, R. W. Taylor.

So it will be seen out of forty-three authorities who have been quoted, thirty are in the affirmative, thirteen in the negative, and though the preponderance of evidence is so decidedly in favor of the view that the two morbid processes are identical, yet when we consider the excellent authorities who are opposed to these views, it would seem that our verdict should be "not proven."

Book Reviews.

A Practical Treatise on Diseases of the Skin. By HENRY G. PIFFARD, A.M., M.D., Clinical Professor of Dermatology in the University of New York, etc. Assisted by ROBERT M. FULLER, M.D. With fifty full-page original plates and thirty-three illustrations in the text. New York: D. Appleton & Co., 1891.

The author of this work is fortunate in being at the same time an accomplished dermatologist as well as a skilled photographer, otherwise he would

scarcely have been able to present us with an atlas consisting almost exclusively of cases which have been under his personal observation.

Cutaneous diseases present such a diversity in their manifestation, that in representing the same disease it is scarcely possible to portray identical appearances.

Unlike text-books, then, illustrations can scarcely be too numerous, and the practitioner only limited in his possession of them by their quality and the condition of his purse. The perfect models in wax and colors by Baretta, the atlas of Hebra, the Sydenham collection, together with the other good atlases which have appeared in recent years, certainly afford the student in this branch of medicine excellent opportunities of acquiring familiarity with cutaneous diseases.

The great majority of the illustrations of skin diseases which are in existence consist of chromo-lithographs of paintings or colored photographs of the diseases represented, the coloring being generally regarded as essential to a correct delineation of the cutaneous lesions.

The work before us is somewhat of an innovation, in that color is disregarded and the reproductions made entirely in black and white from photographic negatives made by the author.

Without considering at length the relative merits of colored or uncolored illustrations of cutaneous diseases, it may be said that while as correct a conception of certain affections can be obtained from a representation of the eruption in black and white, in other and perhaps the majority of diseases a correct use of color aids the student in acquiring a more accurate idea of the affections. The author has, however, with good judgment selected his illustrations with the view of obtaining the best results by the methods employed in illustrating his work. The plates representing ichthyosis, seborrhœa kerativa, eczema of the soles, psorospermosis, melasma, etc., and the illustrations in the text of zoster, keloid, initial lesion of the lip, etc., certainly convey as correct an idea of these affections as could be done by the most carefully prepared chromo-lithographs. A few plates of photo-micrographs of skin sections are introduced which are certainly as well reproduced as pen and ink drawings would have been. With the improvements in the technique of this branch of photography, the methods of microscopic staining, and the engravers' art, photo-micrographs are bound to assume a prominent position in illustrations of pathological appearances, removing as they do the possibility of intentional or innocent deception. The excellent chapter on diagnosis which introduces the text is one of the best expositions of the subject we have ever read, a short chapter on pathology and treatment follows, then the individual diseases are systematically considered.

The condensed style of writing of which the author is a master, enables him to express in a limited space all essential matter.

The author's classification of rodent ulcer with the lupus family will certainly meet with strong opposition from the pathologists, as will his association of lupus vulgaris with lupus erythematosus. Though clinically the three affections present points of similarity, their minute structure is quite different, for while it is generally conceded that lupus vulgaris is a local or modified tuberculosis, there is nothing in the microscopic structure of either rodent ulcer or lupus erythematosus to ally them with tuberculosis. Accepting the view of Unna that his eczema seborrhoicum is an affection of the coil glands

attended with an excessive secretion of fat from them, he proposes the name sudolorrhœa for the affection.

Dermatitis multiformis is proposed as a substitute for the dermatitis herpetiformis of Duhring, and perhaps is a more comprehensive term than the latter. The name employed by Duhring will in all probability continue to be used, especially for that form of the affection in which the grouped character of the lesions is present.

Dr. R. M. Fuller is credited with the chapters on anidrosis, dysidrosis, ichthyosis, and morphœa, and for the negative of plate XXII., an excellent representation of fibroma.

The book presents a most artistic appearance, being printed on heavy cream-tinted paper with wide margins, appealing both to the intellectual and æsthetic sense of the reader. The mechanical execution and printing of the plates and illustrations throughout the text could not possibly be excelled, and the publishers are to be congratulated on the results obtained.

A Dermatological Bibliography. Compiled by GEORGE THOMAS JACKSON, M.D., New York. Presented to the American Dermatological Association in 1889, and issued as a part of its transactions for 1890.

This catalogue comprises over three thousand titles of books on skin diseases and about twelve hundred of books on syphilis and allied subjects. Where it was possible the prices of books are given, as well as the editions and the dates of their publication.

Without claiming to be a complete bibliography, it will serve as a useful guide in the selection of books on these subjects.

Selections.

Lichen Ruber Treated by Tuberculin. DR. MORISON. (*Johns Hopkins Hospital Bulletin*, No. 11, 1891.)

Dr. Morison was led by favorable reports in the *Monatshefte für Prak. Derm.*, December 15th, 1890, to try the Koch lymph in the following case: Louisa E., aged 16, entered the hospital November 19th, 1890, covered with an eruption of three years' standing—skin dry, parchment-like, and scaly, of dull red color and itchy. Over the back was a more recent eruption of small scale-covered papules. The skin of the palms and soles was thickened and split into separate ridges. The nails were hypertrophied and brittle; a fine papular eruption covered the face. The arms and legs could not be stretched out straight on account of the induration and hardening of the skin about the elbows and knee-joints. The general condition was distressing: appetite poor, headache, furred tongue, chills and fever. Patient had had a similar attack when ten years of age, from which she recovered after several years' treatment. Patient did not improve under the usual treatment, and an unfavorable prognosis was made. On January 9th the inoculations were begun, 0.001 being followed by a temperature of 100°. The next day two milligrammes were given and temperature reached 103°. The ninth and last inoculation up to date of report, on February 2d, of five milligrammes, was followed by very little reaction. The changes in the appearance of the skin were marked. The

dull red color disappeared, the face became free from eruption, the joints supple, palms and soles took on an almost normal appearance, and the itching ceased. Desquamation was increased a few hours after each inoculation. No tuberculous disease could be found. The case is not regarded as cured but as wonderfully improved. CHARLES W. ALLEN.

Syphilis of the Lung. DR. COUNCILMAN. (*Johns Hopkins Hospital Bulletin*, No. 11, 1891.)

Dr. Councilman gives an interesting and instructive account of two autopsies recently made on cases of death from lung syphilis. The descriptions of Virchow have formed the basis of most of what has since been written on the subject, and nowhere is there given a careful description of the finer details of the lesions. Virchow was the first to describe the white pneumonia of children, and Hecker showed its association with syphilis—a condition afterward described by Lorain and Robin under the name of epithelioma of the lung, because of the alveoli being closely packed with desquamated fatty epithelial cells. Hiller denies *in toto* the existence of a syphilitic phthisis, and thinks the cavities in the cases which are to be regarded as syphilitic were bronchiectases, and the writer believes, from the description of these cases and from his own experience, that Hiller was right and that there is no condition properly named syphilitic phthisis. In syphilis of the lung there is only the production of connective tissue and dense hyaline gummata, with an entire absence of ulcerative process such as is found in tuberculosis.

The literature of the subject is carefully reviewed and studied, and, exclusive of congenital syphilis of the lungs in infancy and doubtful cases in the adult, the disease seems to the author to be comparatively rare. While it would seem that the lungs were as equally exposed to the syphilitic virus as the liver or other organs, it is pointed out that the virus would not be apt to enter the lungs from the bronchi except in case of syphilitic ulcerative bronchitis. Microscopic examination of the lung in one of the reported cases showed the principal lesions to be foci of interstitial pneumonia, with central necrotic caseous masses, the most striking thing about the latter being the very sharp limitation of the necrotic process. The tissue around the larger necroses was a tolerably firm connective tissue, rich in spindle-cells. The lung tissue outside of the connective tissue, in the portions which macroscopically had an œdematous appearance, proved of most interest, because here the process was more acute. Here decided atrophy of the walls of the alveoli was very noticeable. The alveoli were distended and filled with large, swollen, pale epithelial cells and fibrin. Smooth hyaline masses, in size from that of half the diameter of a red-blood corpuscle to that of the large epithelial cells, were also present, the result of hyaline degeneration of the epithelial cells. In parts obliteration of capillaries was due to hyaline degeneration of these walls. All the bronchi of the affected portions of lung were altered by having their calibre narrowed by reason of a growth of connective tissue into the lumen. In all the portions of the lung affected there was an endoarteritis of the smaller arteries.

In the second case there was found chronic nephritis, hypertrophy of heart, and a syphilitic liver. Amyloid infiltration of the spleen and kidneys. These changes, together with the characteristic lesions of the liver, small

gummata, and bands of fibrous tissue, leave no doubt as to the diagnosis. Both lungs were adherent to the pleurae along the posterior portions. The bronchi were filled with mucus, pus-cells, and desquamated epithelium. More than half the left lung was consolidated ; nearly all the lung not occupied by fibrous tissue was emphysematous, with the alveoli greatly dilated. The arteries showed endoarteritis greatly diminishing the lumen. Caseous nodules in the indurated portion were typical gummata, and in most of the necrotic material there was a complete hyaline degeneration. Nodules beneath the pleura showed a hyaline necrotic centre, surrounded by dense masses of connective tissues with bands radiating into the lung. This case was characterized by marked destruction of lung tissue.

The author thinks that all of the lesions can be best explained by the assumption of a soluble substance, which, having been produced by an organism, enters the circulation and exerts a special action on certain tissues of the body—namely, on the capillary walls—but our lack of knowledge as to the character of the syphilitic organisms makes this mere speculation.

The essential process in the production of gummata in the lungs is a pneumonia with fibrinous exudation, accompanied by fibrous thickening of the alveolar walls, the whole undergoing caseation. The close analogy between tuberculosis and syphilis of the lung is thus shown.

In the gumma the primary process is the atrophy of the alveolar walls, due, the author thinks, most probably to a hyaline degeneration of the capillaries. Most of the cases in literature were published before Koch's discovery made the diagnosis of tuberculosis more accurate, and the author thinks many of them cannot be accepted. Thus of Hiller's eighty-four cases, only twenty-eight should, according to him, be regarded as syphilitic.

In neither of the reported cases could tubercle bacilli be found. Besides the hyaline degeneration of the capillaries, which seems to be the important element and the primary lesion in these cases, the absence of leucocytes in the exudation was made prominent, because all the conditions which they usually accompany seemed to be present. CHARLES W. ALLEN.

Excision of the Chancre as an Abortive Treatment of Syphilis. H. LELOIR. (*Wiener Mediz. Presse*, No. 14, Apr., 1891.)

The author's opinion, after excising many chancres and seeing many others excised, is that in most instances syphilis follows the operation just the same. This has been his experience in three of his most recent efforts. The third case, which is almost identical with one reported by the same author at the congress in Copenhagen in 1884, concerned an intelligent man who presented himself ten days after coitus with a woman who was found, on examination by the author, to be syphilitic with eroded papular chancres on the labium, accompanied by glandular swellings, and who subsequently developed a roseola, etc. Nineteen days after the suspected infection there appeared on the young man's penis a small papule unaccompanied by marked induration or glandular enlargements, and did not show any escape of fluid-ion pressure ; the symptom which the author has advanced as a sign in differ ential diagnosis between chancre and herpes. The lesion was situated on the free margin of the prepuce, and the author did not hesitate to excise it and cauterize the wound thoroughly with the thermo-cautery. Nine days later the wound became indurated and a chancre developed without erosion or ulcera-

tion. Six weeks after excision of the original papule there appeared a discrete roseola, papules on the tonsils, slight glandular swellings in the neck, and alopecia, all of which disappeared after a course of inunctions. Histological examination of the excised papule showed embryonal cells far beyond the limit of tissue which clinically had appeared diseased. These the author regards as the offshoots or roots of the primary syphiloma. While admitting that excision did not here succeed, the author cannot admit that the chancre is a local manifestation of a general condition—the first of the secondary manifestations of syphilis, as Ricord has maintained. The author believes that the observations of Auspitz, Unna, Langenbeck, Rydygier, Kölliker, Pick, Pospelow, Spillman, and De Amicis go to show that it is perhaps possible occasionally in the early stage to entirely remove a primary syphiloma. He cites the following personal observations in support of this: In December, 1884, a young man of twenty-two years contracted a small papule on the free border of the prepuce, which showed itself twenty-four hours after connection with a woman who subsequently came under the author's care and was undoubtedly syphilitic. The chancre when seen was lentil-sized, slightly eroded, round, raised, of a smooth, varnished appearance, and situated on a parchment-like indurated base. The inguinal glands were scarcely noticeably enlarged. Excision was practised, including a wide strip of tissue. Healing took place perfectly in a few days, and no induration or glandular enlargement followed. The histological examination showed the characteristic features usual in chancre. Bacilli were not examined for.

In view of the clinical and histological appearances, the development of the lesion, the confrontation, etc., the author believes the diagnosis of chancre is warranted. The patient came twice each week to be examined, and up to the end of 1888 had shown not the least symptom of syphilis.

Dr. Lenger has related to the writer the following case: In November, 1884, he excised by means of the thermo-cautery a typical chancre. The woman who had infected the patient came under treatment a month later with a well-developed secondary syphilis. The man was seen many times afterward, but never any suspected lesions were found. The excised chancre had all the characteristics of a specific ulcer and was two weeks old. In explanation of such instances of apparent success from the method, the author thinks we may conclude that the virus has not extended beyond the line of incision. New facts bearing on the question must be awaited, and in the mean time excisions should be carried out only on those who desire it and after the state of the question has been explained to them.

According to Jullien (*Union Médicale*, March 5th, 1891), the excision of the chancre should be total. The cut must be wholly in sound tissue, and all the rules should be observed which hold good in operation for cancerous tumors. A few sutures are necessary to close the wound. General anæsthesia is not necessary, as application of cocaine, or, better, interstitial injection, answers every purpose. During the past ten years Jullien has operated eighteen times. Three cases were lost sight of after a few days, three were entirely relieved from any subsequent manifestation of syphilis, and the remainder were negative: all showing general symptoms of syphilis. A fourth patient had the disease so attenuated, if not eradicated, that he contracted a second infecting chancre.

In two cases after excision the chancre returned, and in one instance recurrence of the sore in situ made three successive operations necessary. The

author believes the operation proper whenever the chancre dates from a few days only, and the glands have remained free from all specific implication, and especially if it is sure that the chancre and a wide surrounding zone of tissue could be removed.

Wickham takes issue with Jullien on the utility of excision, and thinks that only the first of the three instances cited by him as successful can be regarded as final. He believes more precise observations are necessary to prove the beneficial effects of excision of the chancre. CHARLES W. ALLEN.

Purpura Hemorrhagica. DR. AGNES LOWRY. (*Medical Record*, May 9, 1891.)

Dr. Agnes Lowry considers it essential that the etiology and pathology of purpura should be entirely rewritten to meet the requirements of modern teaching and the discovery by Letzerich of pathognomonic micro-organisms. The author regards it as probable that all forms of disease characterized by the symptoms of constitutional infection and spontaneous hemorrhages may be included under one head. Even those supposed to be symptomatic will probably be found to be produced by the bacillus of purpura hemorrhagica co-existing with some other.

Purpura rheumatica is regarded as an undoubted form of purpura hemorrhagica, and it is thought the term rheumatica should be dropped. It would further seem to the writer logical to include in the same category with the purpuras, if not in the same class, those diseases comprised by Kaposi under the heading Erythema Exsudativum Multiforme.

CHARLES W. ALLEN.

The Stone Disease in Russia. G. RADSEWITSCH, of Nishnji Nowgorod. (*Centralbl. f. d. Physiolog. und Patholog. der Harn- und Sexual-Organe*, Bd. II., Hft. 5, 1890.)

Dr. Radsewitsch has found as the results of his studies on this subject that stone in the bladder is of great rarity in the northern parts of Russia. In examining the records of the disease in thirteen provinces of northern European Russia he was able to find only 190 cases reported within the last one hundred years. F. TILDEN BROWN.

The Treatment of Non-operable Cancers by Means of Interstitial Injections of Pyoktanine. (*La Tribune Médicale*, April 2d, 1891.)

V. Mosetig is reported to have presented before the Society of Physicians of Vienna (March 13th) several cases of cancer materially improved by injection of pyoktanine:

1. A woman with sarcoma of the lower jaw. After fifty injections (in all 120 grains of pyoktanine) considerable diminution in size of the tumor.

2. Sarcoma of the sternum. Only the fibrous stroma of the tumor remained.

3. A man, 58 years of age, suffering for eight months with sarcoma of the tongue and floor of the mouth. Result: removal of all bad odor and pain; the tongue has become again mobile.

4. Female, aged 47, with an epithelioma of the face. Twenty-seven grammes of pyoktanine used, with the result that the infiltration is less hard, several nodules have separated off; the general condition has much improved.

Amelioration was also obtained in a woman with cancer of the bladder and in a man with an adeno-cancer of the pelvis. In the former there was cessation of the hæmaturia; in the latter, the tumor diminished three-quarters in size. Mosetig recommends that the solution be made of the strength of one part pyoktanine to 500 of liquid; the injection, containing two to three grammes of the active substance, should be made at the periphery of the tumor on a level with the healthy tissue.

Under the influence of the injections, the pains are said to disappear, the tumor is observed to gradually diminish in size and to become in part sloughing, in part to soften and to undergo fatty degeneration and absorption. Billroth, on the other hand, had tried the staining fluids in about thirty cases without ever having observed absorption or diminution in offensive odor Sometimes a softening of the tumor was seen, but it could be considered as due to an aggravation of the disease rather than to anything else.

In the same journal (May 21st), Mr. Quinn reported before the Chirurgical Society of Paris that he had used injections of pyoktanine in tubercular as well as cancerous cases. In the former, no result whatever was obtained, in the latter, slight amelioration.

In a case of epithelioma of the mouth, the injections were followed by very marked facial œdema. In a case of lympho-sarcoma of the thigh, ten injections were made. The centre of the tumor was softened, but not the slightest influence was exerted on the periphery. GEORGE T. ELLIOT.

A New Form of Rhinoscleroma. A. D. PAWLOWSKY. (IV. *Russian Medical Congress*, Moscow, 1891. *Centralblt. f. Chirurg.*, No. 18, 1891.)

Two cases of rhinoscleroma of a hitherto undescribed form are recorded. The affection occurred in the form, clinically, of typical nasal polypi, in one case affecting the right nasal passage, in the other, both. The tumors had grown slowly during one and a half and three years respectively. In one case the skin over the nose was movable and apparently wholly unaffected; in the other it was fixed and tense. The growths were removed surgically and the diagnosis established by the microscope. S. POLLITZER.

On Phthiriasis of the Pubis. A. FOURNIER. (*Journ. des Maladies Cutanies et Syph.*, March, 1891.)

Prof. Fournier states that the pediculus pubis is met with much more frequently in private practice and in the better classes than in those who apply to hospitals for treatment. Three orders of symptoms are found; the pruritus, the pedicular prurigo, and the maculæ cœruleæ. The symptomatic eruption consists of small pink or reddish papules distributed over the pubic regions. These papules are always dry.

In its treatment, the patient should first bathe, then rub into the affected surface ʒ i. to ʒ ij. of mercurial ointment. This should remain for two hours and be followed by a soap and water bath. At the end of forty-eight hours, this treatment should be repeated, if there is reason to suspect that any of the pediculi have escaped the first application. After each inunction the patient's underclothes and bed-linen should be changed, the outer clothing fumigated with sulphur. This manner of treating pediculi pubis is, however, dirty, and exposes the patient to mercurial eczema and erythema, and besides salivation is very frequent after inunctions of the scrotum, anus, etc.

These objectionable features accompanying the usual treatment may be obviated by using a calomel ointment (1 in 20), or better by means of mercurial baths (grs. 150 in usual amount of water for a bath), in which the patient remains a half to three quarters of an hour.

The following lotion is also recommended :

℞ Aq., ... 400.
Alcohol, ... 100.
Corrosive sublimate, ... 1.
M.

Or,

℞ Vinegar, ... 300.
Hydrarg. bichlor., ... 1.
M. S. Dilute one-half with water.

The nits are to be destroyed by means of warm vinegar, diluted with a little water, and after that they can be removed by using a metallic comb.

GEORGE T. ELLIOT.

Treatment of Circumscribed Patches of Psoriasis. E. BESNIER. (*Rev. gén. de Chir. et de Thér.*, 1890.

B. recommends for small patches on the scalp,

℞ Acidi pyrogallic.,
Ichthyol.,
Acidi salicylici, ... āā 4 to 5.
Vaselini, ... 35.
M.

Or for isolated patches,

℞ Saponis virid.,
Vaselini, ... āā 20.
Ichthyol., ... 2.
Acidi salicylic.,
Acidi pyrogallici, ... āā 1.
M.

Daily frictions should be made and continued unless the scalp becomes irritated.

GEORGE T. ELLIOT.

Lymphangioma Circumscriptum. F. A. NOYES and L. TÖRÖK. (*Monatshefte f. prakt. Dermatol.*, XI., 2 and 3.)

A case of this rare affection occurring at the Charing-Cross Hospital in London, is recorded clinically, and the ten cases previously published are briefly reviewed. The author's case, a girl, ten and a half years old, developed the lesion in question in her third year. It began on the neck as a small spot resembling the blister from a burn. Similar vesicles continued to develop around it from time to time, till at the time of the examination there was a patch the size of a child's hand on the left side of the neck extending from the border of the hair obliquely downward to the seventh cervical vertebra. It is made up of vesicles from a pin's head to a pea in size, some of them crossed by one or more dilated capillaries. The contents of the vesicles are clear in most cases, and they are not attended by pressure. No subjective symptoms.

All the lesions which have been described under this and similar names, consist anatomically of cavities and dilated convoluted canals in the papillary and subpapillary layers, which contain lymph or blood, or both. The process consists essentially of a proliferation of angioblasts with new formation of lymphatics and blood-vessels and development into cavernous spaces and wide canals. After an exhaustive review of the entire literature of the subject Török divides the capillary lymphangiomata into three classes: 1, varicose lymphangiomata; 2, tuberose (fibromatous) lymphangiomata; and 3, cavernous lymphangiomata. The first of these affects only the upper layers of the cutis, the other two forms affect the entire cutis, excepting only its uppermost layers. S. POLLITZER.

Items.

Preliminary Programme of the American Dermatological Association.

President's Address. Dr. F. B. Greenough, of Boston.

Discussion on Tuberculosis of the Skin.

Its Clinical and Etiological Features. Dr. J. C. White, of Boston.

Its Pathology. Dr. J. T. Bowen, of Boston.

Its Treatment. Dr. G. H. Fox, of New York.

Discussion on Nomenclature.

A Therapeutic Note on Alopecia Areata. Dr. L. D. Bulkley, of New York.

The Treatment of Alopecia Areata. Dr. P. A. Morrow, of New York.

Remarks on Carbuncle, with a Report of a Peculiar Case. Dr. H. G. Klotz, of New York.

Dermatitis Hæmostatica. Dr. H. G. Klotz, of New York.

Note on Erythema et Nævus Nuchæ. Dr. C. W. Allen, of New York.

A Case of Lichen Ruber. Dr. J. Grindon, of St. Louis.

A Case of Lichen Scrofulosorum. Dr. J. Grindon, of St. Louis.

A Case of Lupus Erythematosus with fatal Complications. Dr. W. A. Hardaway, of St. Louis.

Lymphangioma Circumscriptum, with Report of a Case. Dr. M. B. Hartzell, of Philadelphia.

Molluscum Contagiosum. Dr. J. E. Graham, of Toronto, Canada.

Morphœa Atrophica of Wilson. Dr. R. W. Taylor, of New York.

A Study of Mycosis Fungoides, with Reports of two Cases. Drs. Stelwagon and Hatch, of Philadelphia.

Diseases of the Skin associated with Derangements of the Nervous System. Dr. W. T. Corlett, of Cleveland.

Prairie Itch. Dr. L. N. Denslow, of St. Paul.

The Treatment of Pruritus. Dr. E. B. Bronson, of New York.

Note relative to Pemphigus Vegetans. Dr. J. N. Hyde, Chicago.

The Personal Element in Dermatology. Dr. L. D. Bulkley, of New York.

An Unusual Case of Sarcoma involving the Skin of the Arm. Amputation. Recovery. Dr. F. J. Shepherd, of Montreal.

Multiple Sarcomata. History of Case showing Modification and Amelioration of Symptoms under large Doses of Arsenic. Dr. S. Sherwell, of Brooklyn.

Thirteen Cases of Tuberculosis of the Skin with their Treatment. Dr. J. S. Howe, of Boston.

GEO. THOS. JACKSON, Secretary.

Preliminary Programme of the American Association of Andrology and Syphilology.

The Fifth Meeting of this Association will take place at the Shoreham Hotel, Washington, D. C., on September 22d, 23d, 24th, and 25th, 1891, in connection with the Congress of American Physicians and Surgeons.

Daily Sessions will be held from 9 A.M. to 1 P.M.

The following papers have been promised :

A Review of the Evidence of the Transmission of Syphilis to the Third Generation. By Dr. Abner Post, of Boston.

Relation of Syphilis to Stricture of the Rectum. By Dr. R. W. Taylor, of New York.

Surgery of the Ureter. By Dr. A. T. Cabot, of Boston.

Some Experience with Suprapubic and Perineal Drainage, Temporary and Permanent, in Vesical Disease. By Dr. Edward L. Keyes, of New York.

Stricture of the Ureters. By Dr. Francis S. Watson, of Boston.

On the Radical Cure of Urethral Stricture by Restoration of the Mucous Membrane to the Normal Condition. By Dr. John P. B. Bryson, of St. Louis.

Observations upon the Syphilitic Cachexia. By Dr. J. Blake White, of New York.

An Obscure Case of Chronic Non-Specific Urethritis of Sixteen Year's Standing. By Dr. George E. Brewer, of New York.

New Methods for the Treatment of Urethral Disease Effected by the Use of the Speculum. By Dr. F. Tilden Brown, of New York.

Rupture of the Bladder. By Dr. A. T. Cabot, of Boston.

Encysted Stone, Complicated with Growths of the Bladder. By Dr. C. H. Mastin, of Mobile.

On the Use of Salicylic Acid in the Treatment of Certain Forms of Cystitis. By Dr. John P. Bryson, of St. Louis.

The Dry Poultice in the Treatment of Epididymitis. By Dr. George E. Brewer, of New York.

Spontaneous Fracture of Stone in the Bladder. By Dr. Francis S. Watson, of Boston.

Exhibition of an Antiseptic Syringe for Hypodermic Medication. By Dr. J. Blake White, of New York.

On the Occurrence of Nephritis in Early Syphilis. Dr. J. A. Fordyce, of New York.

Exhibition of Complete Double Ureters of both Kidneys. By Dr. Edmund E. King, of Toronto, Canada.

The Treatment of Stricture of the Urethra. By Dr. L. B. Bangs, of New York.

Further Report of a Case of Tubercular Cystitis. By Dr. L. B. Bangs, of New York.

Reflections Suggested by some Recent Prostatectomies. By Dr. Edward L. Keyes, of New York.

Clinical Notes on (a) Hypertrophy of the Prostatic Sphincter ; (b) Relation of Rectal Distention to Arterial Depression. By Dr. William T. Belfield, of Chicago.

Treatment of Gonorrhœa. By W. Frank Glenn, of Nashville, Tenn.

Treatment of Vesical Calculus in Male Children. By Dr. J. William White, of Philadelphia.

Abortive Treatment of Syphilis. By Dr. J. William White, of Philadelphia.

Undetected Stone. By Dr. Wm. H. Hingston, of Montreal.

J. A. FORDYCE, Secretary.

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Original Communications.

A CASE OF MULTIPLE DERMOID CYSTS SIMULATING XANTHOMA TUBEROSUM.

BY S. POLLITZER, A.M., M.D.,
New York.

HENRIETTA DICK, aged 24 years, housemaid, applied for treatment at the out-patient department of Charing Cross Hospital, London, in March, 1890, for a squamous ulcerating syphilide of the legs. The syphilis had been acquired about three years before, presented no unusual features, and does not interest us here. At the time of her examination, there was found scattered over the body another eruption which forms the subject of this paper.

The patient is well nourished, and excepting the cutaneous syphilis, in good health. She has had three attacks of articular rheumatism and one of pleurisy with effusion. She has been a sufferer for many years from occasional attacks of migraine. A careful examination failed to detect anything abnormal in the heart, lungs, kidneys, etc.

The eruption in question appeared about seven years ago behind the ears, and very soon after on the neck, arms, and scalp; three and a half years ago it was observed on the chest, back, and buttocks, and during the past year has increased very considerably on the chest.

At present the chest and back are dotted over with little tumors, varying in size from a little more than a pin's head to a small hazelnut, in color from a lemon yellow to that of the normal skin. They are distinctly circumscribed, spherical in shape, lifting up the epidermis under which they can for the most part be rolled about. On the scalp, over the mastoid processes—where they are numerous—over the clavicles, and in general where the integument is thinly stretched over bone, the little tumors are flat rather than spherical, rise more abruptly above the surrounding skin, and are of a distinctly lemon-yellow color. There are a few in the epigastric region, a considerable number over the rest of the abdomen, and over the buttocks. In these

regions many more can be made out on passing the finger over the surface; they are not visible, but become apparent to the finger on palpation. A few nodules appear on the front of the forearms, some of them yellow, others normal in color, and two are present on the palmar surface of the index finger of the right hand, and one on the left thumb. One small nodule may be felt on the right cheek.

Altogether there were about 150 of these little tumors scattered over the integument.

The growths occasion no subjective symptoms. The patient asserts that she has been able to cause the disappearance of some of the tumors on the chest by pressure, and they have not recurred. She has also pricked open the skin over some of them, producing a little ulcer which did not heal readily.

The diagnosis of *xanthoma tuberosum multiplex* was made and the case very kindly submitted to me for study and publication, by Dr. Sangster, in whose charge the patient was.

For the purpose of histological examination a number of the tumors from the mastoid region, the neck, and the back—ten in all—was excised and fixed, some in Flemming's solution, others in alcohol, embedded in celloidin, cut, and stained in the usual way. A single glance at the sections showed that the diagnosis of xanthoma was wrong, and that the tumors were typical dermoid cysts, the cyst-wall presenting a well-marked papillary layer, the contents made up of the usual cornified and degenerated epithelium and detritus, and in most cases a coil of hair. Most of them contained, besides, a large quantity of brownish and black pigment, derived probably from the horny tissues.

The papillary layer and epidermis over the cysts contained only the usual amount of pigment. It is therefore to the pigment masses in the cysts that the yellow color of the nodules must be ascribed. The yellow color it has been stated was most pronounced in those nodules which lay over the mastoid processes, the clavicles, etc. In such regions the skin over an atheromatous cyst ordinarily appears yellowish-white (the color of the epidermis) from the ischæmia due to pressure on the vessels in the cutis between the tumor and the stretched epidermis. If, as in these tumors, there is a dark background under the epidermis, a darker shade, merging into a more marked yellow, will naturally result.

In the papillary layer over one of the cysts, between the cyst and the epidermis, nearly all the blood-vessels were found to have their lumina partially or completely filled out with proliferated endothelium. This endarteritis obliterans is, I believe, only an accident in this place, and is to be ascribed to the syphilis with which the patient was affected. Endarteritis is an extremely common occurrence in all syph-

ilitic processes, and the localization of syphilitic manifestations we know from Fournier's and Haslund's statistics is largely determined by accidental lesions of any nature whatever. The cyst, we can readily conceive, must, like a foreign body, have been a source of irritation to the neighboring tissues, and the patient was besides in the habit of pressing on some of the tumors with the idea of causing their dispersion. This particular tumor may have been one of those specially irritated in this way, and sufficient injury may have been done to start a syphilitic endarteritis, which would, perhaps, have gone on to the development of a frank syphilitic lesion had not the tumor been excised.

Dermoid cysts are of course of extremely common occurrence. It is no exaggeration, I believe, to assume that one person out of five will be found on careful examination to present a cutaneous dermoid. The current theory of their genesis by sequestration from the surface epiblast sufficiently accounts for the frequency of their occurrence. But cases in which the number of these cysts is so great as in that here described are extremely rare. Jamieson[1] records an interesting case of this kind. An Irish laborer, aged 45 years, suddenly developed 250 tumors from a pea to a large nut in size. The skin over most of them was normal in color, some however were greenish [yellow?], others reddish in color. They were situated chiefly on the trunk; some appeared also on the face, the scalp, and the extremities. The tumor which appeared first—on the sternal end of the right clavicle—disappeared after a time. Many others similarly disappeared spontaneously—were absorbed. None ruptured. A large one was excised; it was filled with "a thick brownish liquid which contained numerous epithelial cells." The patient displayed great physical weakness without assignable cause.

As to the error in the clinical diagnosis, I do not see how it could readily have been avoided. Dr. Sangster was a member of the London Pathological Society's "Xanthoma Committee," and I have myself seen a fair number of cases of xanthoma tuberosum. It is interesting to note that a similar mistake in diagnosis was made before. Two of the sixteen specimens obtained in Neisser's clinic in Breslau, on which Touton based his elaborate study of xanthoma, proved to be dermoid cysts. I have no doubt that if one of the tumors had been incised, its fluid contents would have given the clue to a correct diagnosis, and I would recommend this simple proceedure in all cases of xanthoma tuberosum in which the diagnosis may not be verified by a microscopic examination.

21 West 52d Street.

[1] Case of numerous cutaneous cysts scattered over the body: Edin. Med. Jour., Sept., 1873, p. 223.

SOME REMARKS UPON THE DIAGNOSIS OF GONORRHŒA IN THE MALE. NO. 1.

By SAMUEL ALEXANDER, M.A., M.D.,

Professor of Genito-Urinary Surgery, Syphilology, and Dermatology in the Bellevue Hospital Medical College, Surgeon to Bellevue Hospital, etc.

THE following article contains in substance some remarks made at a clinical lecture delivered during the last spring session at Bellevue. Although it is, therefore, elementary, it is published for the purpose of calling attention to a subject which I believe is too often neglected. I hope, however, that the suggestions made as to the methods of diagnosis in urethritis may be of practical value to some readers of the journal. They are methods which can be adopted by the general practitioner. I have endeavored to call attention only to the more important points, and to show the advantage of a systematic mode of proceedure.

The diagnosis of urethritis to be of any practical value includes much more than giving it a name. It involves a correct estimate of its nature and of its affinities.

There is probably no subject upon which more has been written by surgeons than upon the treatment of urethritis, but the subject of its diagnosis has received very little attention until within recent years. Our present knowledge of the anatomy of urethritis, and the means which we now possess for examining the urethra, make it possible to arrive at a very accurate estimate of the extent and character of the inflammation in every case. The very serious consequences which may follow from a neglected or unproperly treated urethritis, demand, on the part of every physician who undertakes the treatment of the disease, the utmost care in the diagnosis of every case. I am convinced that if the importance of this were more generally appreciated we should in future have fewer cases of stricture, cystitis, and other affections following so frequently as the result of neglect in this respect.

The principal facts upon which a diagnosis is formed in any case of urethritis relate to, 1st, the nature of the disease; 2d, the intensity of the inflammation; 3d, the portion of the urethra affected; 4th, the extent of the inflamed area; 5th, the character and appearance of the anatomical changes. We should also in some cases take into consideration the constitution, the habits, and the environment of the patient.

We determine the nature of the disease by microscopical examination of the discharge; its intensity by the appearance of the discharge, and by the subjective symptoms, especially the symptom of pain; the

portion of the urethra affected by the discharge and urine; the extent of the inflamed area by instrumental and physical examination, and by direct ocular inspection of the urethra.

We will now look at the method of obtaining these facts more in detail.

1. The conditions under which an examination of the urethra should be made. The best time to make an examination of a patient suffering from urethritis is after he has retained his urine for several hours, so that the bladder is moderately distended. This is a point of great importance which is frequently overlooked. If a patient is examined immediately after he has passed water, it will be impossible to determine either the nature of the disease or to tell with any precision the extent or the intensity of the inflammation, as the discharge will have been washed entirely away from the urethra. When, therefore, a patient comes to be examined for the first time if his bladder is empty, it is wiser to defer the examination, and the patient should be instructed to present himself for examination in the future with at least a moderate amount of urine in his bladder.

2. Intensity. The intensity of an urethritis is determined by the character and amount of the discharge, and by the subjective symptoms, especially the symptom of pain. The discharge in urethritis may flow in drops from the meatus or it may be so slight that it cannot escape, and it may then be seen in the urine in the shape of threads, or small, white particles. The more intense the inflammation the more profuse and abundant will be the discharge, and the more painful will be the act of micturition. The color of the discharge varies from a greenish-yellow pus, to an almost transparent mucoid fluid in which may be found a few leucocytes and epithelial cells. The latter is nothing more than an increase of urethral mucus such as is seen after a prolonged congestion of the mucous membrane. In acute urethritis the discharge is thick and purulent, and clouds the urine uniformly. As the intensity lessens the discharge becomes more mucopurulent and diminishes in quantity, finally the free pus disappears from the urine. We find also the discharge in the urine as threads, and small, white, choppy particles; these are especially prominent after the inflammation has become localized and chronic. These threads and white particles consist of tenacious mucus in which are layers of epithelia, and pus cells. The relative proportion of the two kinds of cells varies with the intensity of the discharge. In chronic inflammation of the prostatic urethra we may find, in addition to these cells, spermatic elements, prostatic corpuscles, and corpora amylacea.

In some cases of chronic urethritis, no discharge appears at the

meatus, and the more chronic the case the scantier does the discharge become. Little information, however, can be obtained in regard to the amount of the discharge in any case by simply inspecting the meatus. The only accurate method of estimating the quantity is to observe the amount of deposit in the urine after it has been standing. In estimating the relative amount from day to day, it is necessary to take into consideration the quantity of urine passed at the time of the examination and the length of time during which the discharge had been collecting in the urethra.

3. The nature of the inflammation. In every case of urethritis the question has to be decided whether or not the discharge is gonorrhœal. This is done by making a microscopical examination of the discharge and depends upon the presence in it or absence of the gonococcus. The method of staining and examination is so familiar, that I shall only call attention here to one or two points of special importance. The responsibility which is often placed upon a physician in deciding this point is so great, that an opinion should never be given in a doubtful case upon the results of a single negative examination.

In making the examination, the pus should be taken from inside the urethra, and it is best to press the pus from the deeper parts of the canal; the threads and choppy particles which are washed from the urethra by the urine should also be examined. In cases of doubt, I usually give to the patient two cover glasses, and instruct him to prepare upon them for staining the pus which can be pressed out from the urethra upon rising in the morning, and to bring these to me for examination. I have in some cases been able to find the gonococcus in this way when I had failed in every other. A negative result in a single examination for the gonococcus should never be taken as conclusive evidence of the non-gonorrhœal nature of the disease. A single positive result, provided the gonococci are typical in shape, grouping, staining, and are found *within* the pus-cells, is conclusive. When the inflammation is recent, the gonococci, if present, are usually easy to find, and they increase in number with the intensity of the inflammation, but toward the end of the disease they may be difficult to find, and it may be necessary to make many examinations at different times, in order to decide the question.

4. The extent of the inflammation. The next question which presents itself is in regard to the extent of the inflammation. In acute urethritis we need only determine whether it is the anterior portion of the urethra that is inflamed, or whether the disease extends to the posterior portion. The subjective symptoms may give us some information, but the more exact method is by means of the "two glasses test" suggested by Sir Henry Thompson. The patient is requested to pass

water in two separate parts. The first and greater portion is passed into glass No. 1, and the remainder into glass No. 2. If the anterior urethra alone is inflamed, the urine in glass No. 1 will be cloudy or will contain threads and that in No. 2 will be clear. If the urine in glass No. 2 is cloudy or contains threads or particles, there is posterior urethritis. An error may possibly be made here if there be but a little urine in the bladder when the test is made. In such a case the urethra may not be wholly freed of the discharge by the first gush of urine, and then the urine in glass No. 2 will be cloudy from pus derived from the urethra. The reason that in acute cases the cloudiness of the second specimen of urine is a sign of posterior urethritis, is because the neck of the bladder is usually also implicated at the same time, and also because the discharge from the deep urethra when profuse flows back into the bladder and renders the urine there cloudy. It is a good plan to have the patient make this test with the first urine passed in the morning, and I usually direct patients to pass their "morning urine" into two bottles and to bring these for my inspection. In acute anterior urethritis, the extent of the disease may be more accurately determined, by pressing with the fingers along the course of the urethra upon the under surface of the penis, and noting how far back it is sensitive. In this way also the little round lumps in the urethra which denote follicular inflammation can be easily detected. It is well to bear in mind that persons who have formerly suffered from posterior urethritis and its complications, epididymitis, prostatitis, and cystitis, are more likely to have the same troubles again should they acquire a fresh urethritis, than are those in whom only the anterior urethra was involved at a previous time. It is important, therefore, to obtain in every case of urethritis information in regard to the character, duration, and extent of any former urethral disease, inquiring especially whether at any time during the former attacks the patient suffered from frequency in passing water, whether the end of the act was accompanied by much pain or tenesmus, and also whether either testicle was attacked by the disease. I consider this to be a precaution of considerable importance.

In all cases of epididymitis, prostatitis, and cystitis arising during the course of an urethritis, there is always a posterior urethritis of the same grade, which is primary, and from which the inflammation spread to these parts. This urethritis must be first treated before we can expect to control the disease in the testicle, bladder, or prostate.

In a person suffering from his first gonorrhœa, the posterior urethra is rarely inflamed until the second or third week of the disease. When it is met with at an earlier date, it is usually either due to the fact that the posterior urethra has been inflamed recently, or to excess

in alcoholic drinks, or to sexual excitement, or because the patient is tubercular, syphilitic, scrofulous, or debilitated by disease.

When inflammation begins in the posterior urethra the anterior urethritis rapidly subsides.

In chronic urethritis we have usually but few subjective symptoms unless the posterior portion of the urethra is involved, when there may be more or less frequency in the desire to pass water, with or without tenesmus and urgency.

The discharge in chronic urethritis is comparatively small in amount, even when a considerable extent of the urethra is involved. In some cases no discharge is visible at the meatus except, perhaps, in the morning a drop or two may be pressed out of the meatus. In other cases, especially when the inflammation is confined to the bulb or to a limited area in the anterior urethra, the lips of the meatus will be found glued together on rising in the morning.

In many cases of chronic posterior urethritis, it is impossible to tell by the "two glasses" test that this part of the urethra is diseased. The discharge is so small in amount that it does not enter the bladder and cloud the urine, because, before enough discharge has collected, it is washed away by the flow of urine. To determine the existence of posterior urethritis, it is better to use the following method which I believe was suggested at first by Zeissl, and which I have used for several years with much satisfaction.

A small soft-rubber catheter, or a straight metal catheter having two openings, one on each side of the instrument and placed as near its extremity as possible, is introduced into the anterior urethra until the extremity is in the bulb. To this a fountain or hard rubber piston syringe is attached, filled with pure hot water, and the anterior urethra is thoroughly irrigated. The catheter should be rotated from time to time, during the flow of water. In this way all the discharge from the anterior portion of the canal is washed away. The amount of this discharge can be estimated by examining in a glass the wash returned from the urethra. The patient immediately after the catheter is withdrawn from the anterior urethra, should pass water into two glasses, No. 1 and No. 2. In the first glass we shall have the discharge from the posterior portion of the urethra if it is inflamed. If the urine passed in the first glass is free from pus or from threads or flakes, then the posterior portion of the urethra is not inflamed. If the urine in the second glass contains pus, it shows that there is inflammation in other portions of the urinary tract, most probably in the bladder. If the urine in both the first and second glasses is clear, and the wash is cloudy or contains threads or choppy particles, the inflammation is confined to the anterior portion of the urethra.

Having determined thus in this general way the portion of the urethra which is inflamed and the intensity of the disease, we have next to determine the exact position of the inflammation, and as far as possible, get a clear conception of the appearance of the anatomical changes which exist.

In cases of *acute inflammation*, either of the anterior or deep urethra, it is not advisable to make any further examination than that which will determine the extent of the inflammation with reference to the compressor urethræ or cut-off muscle, because we can assume that in these cases the inflammation, except just at its onset, is general. Thus in acute anterior urethritis due to gonorrhœal infection the inflammation, although it begins at the meatus, very soon, in the course of a few days, extends backward as far as to the bulb of the urethra. In acute posterior urethritis it may be assumed that the disease extends generally throughout this portion of the canal. Practically, when we have to deal with an *acute* posterior urethritis, we can disregard for the time any anterior urethritis which may coexist, because until the posterior urethritis has been brought under control, it is useless to attempt to treat the anterior portion of the urethra.

In chronic urethritis, and also in some of the subacute cases, more exact methods of localization are necessary.

One method of more accurately locating inflamed areas in the

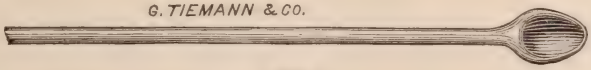

Fig. 1.

urethra, is founded upon the fact that the diseased portion of the urethra is more sensitive than the healthy portion. The examination is made with a bougie à boule, and it is a useful proceeding because at the same time the so-called calibre or distensibility of the urethra can be roughly estimated. In making this examination, an instrument as large as the meatus will admit should be selected. I prefer for this purpose the French soft bougie à boule to that made of metal. The instrument should be oiled and passed through the urethra as gently as possible, and the points of greatest tenderness and their extent should be noted. If the patient is composed and intelligent, the examination may afford valuable information; but if, as often happens, the patient is nervous and hyperæsthetic, very little reliance can be placed in the result.

The anterior portion of the urethra should be first examined in this way, and if the withdrawal of the instrument bring blood, the existence of granulations may be supposed. The deep urethra should then be explored in a like manner. This mode of examination, to be

of any practical value, should be performed two or three times at the same sitting; if then the same points of tenderness are detected at each passage of the instrument they may be relied upon as indicating the seat of the disease. In cases of posterior urethritis, especially when the membranous urethra is inflamed, the instrument may fail at first to pass the compressor urethra, on account of spasm. If, however, the instrument is large in size and is held steadily against the face of the muscle, it will after a time overcome this and enter the bladder with a jerk. The passage of the instrument through the prostatic urethra, when there is inflammation of the prostate itself, sometimes will cause an intense spasm, and the instrument when it is withdrawn may be followed by a discharge of prostatic fluid.

By using the bougie à boule we may localize accurately in most cases, as I have said, the inflamed area or areas, and by the tests with the glasses preceded by irrigation, we may determine the portion of the urethra involved. But we are not made any wiser by these methods concerning the appearance of the inflamed area or areas. Ever since the beginning of the century, the idea of ocular inspection of the urethral mucous membrane has been before the profession. Within the last few years this has been rendered possible by various adaptations of the electric light to the endoscope and urethral speculum. Leiter's electro-endoscope is, perhaps, the best known of those which have been introduced of late years. It is a great improvement upon all those which preceded it, but it is by no means an ideal instrument. It requires both hands for its proper manipulation, it is too heavy, and is likely, except in very practised hands, to give pain. The instrument which I prefer is that figured in Plate No. 2, and is a combination of Klotz tube and the reflector and light designed by Dr. W. K. Otis. Dr. Otis showed me his first model early last winter. I immediately had one made by Tiemann & Co., the instrument makers, with some trifling modifications and this was fitted with a screw arrangement so that the same lamp can be used upon four tubes of different sizes.

Another means of making an ocular examination of the urethra is by means of Dr. F. T. Brown's speculum and urethral mirrors, described in the July number of the JOURNAL. I have had these in my possession for over four months past, the speculum for nearly two years. I have used this method frequently, but do not like it as well as the endoscope pictured in cut No. 2. Dr. Brown's instruments are certainly very ingenious and in his hands seem to be satisfactory, but they require long practice to become familiar with their uses, and are not adapted for general practice. I believe, also, that they cause more pain than the ordinary tubes do, and if one has become familiar

with the morbid appearances of the urethra, as seen with the tube, he must become familiar with the changes which are produced by the speculum on account of the tension which it exerts upon the urethral mucous membrane. In some exceptional cases of warty growths and of follicular diseases of the urethra, Dr. Brown's instrument is to be preferred to the tube, but for ordinary use I cannot conceive of a more practical or more simple endoscope than my own modification, if it may be so called, of Dr. Otis's light, and of Klotz's tube.

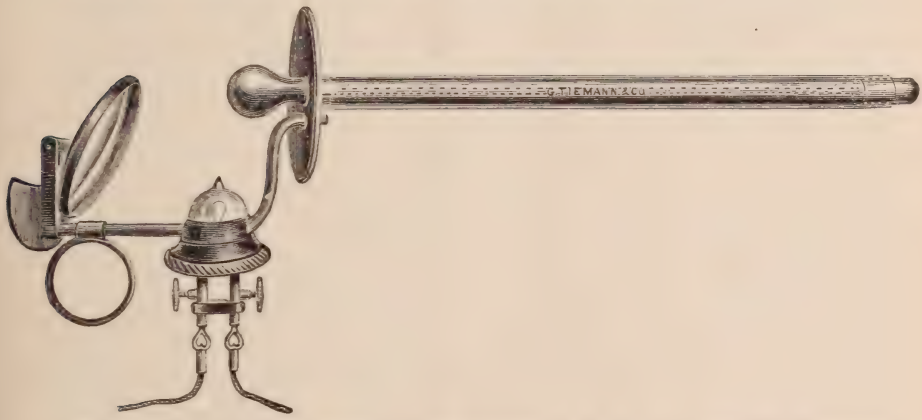

Fig. 2.—The Author's Adjustment and Combination of W. K. Otis' Light and Reflector and Klotz's Tube, Reduced to about One-Third Size.

The use of the endoscope I consider to be indispensable to a proper diagnosis in many cases. There is, however, a tendency at the present time to use it too often, especially in the treatment of urethritis. The endoscope, I believe, should be employed by the student until he becomes familiar with the morbid appearances of urethritis. As an aid to diagnosis it should certainly not be employed until the disease has become localized, for until this occurs we can gain sufficient information by the other means at our disposal. As long, therefore, as there is in the urine much free pus there is considerable danger of intensifying the inflammation by the introduction of the endoscope.

It is useless to use a small tube for exploration. The best size is No. 28 F., and in cases in which the meatus will not admit this size, I prefer to divide it, rather than employ a smaller tube. The endoscope can be easily introduced into the posterior urethra, but it is sometimes difficult to get a very clear view of the prostatic portion of the urethra.

The morbid changes which the endoscope brings to view cannot be taught except clinically. A physician must personally become familiar with the appearances of urethral disease. But first of all, every

physician should make himself familiar with the normal appearances of the different parts of the urethra, which are liable to considerable variation.

In a subsequent article I shall endeavor to call attention and to describe the ocular appearances in the healthy and in the inflamed urethra.

In closing this article I desire to call attention to the method of diagnosing a condition which I believe is more common than is generally supposed, and which is often mistaken for a chronic posterior urethritis—the latter condition being always coexistent. I refer to suppurative seminal vesiculitis.

In order to detect this condition, the examination should be made when the bladder is full of urine.

The patient first passes a portion of his urine into a glass, this frees the urethra of all discharge. The surgeon should then introduce his finger into the rectum and having reached above the seminal vesicle upon the left side, he should press upon it, and endeavor to milk out its contents into the urethra. Having done this the patient passes a second portion of urine into glass No. 2. The right seminal vesicle is then milked out and the remaining portion of the urine is passed into glass No. 3. If the left seminal vesicle is inflamed, glass No. 2 will contain pus, a little blood, and spermatic fluid mixed with the urine. If the right seminal vesicle is inflamed, glass No. 3 will contain these elements. In glass No. 1, the discharge from the urethra will be found. I have seen, during the past year, six cases of this disease, all of which had been mistaken for posterior urethritis.

95 Park Avenue, New York.

A CASE OF "LATE SYPHILITIC EPIDIDYMITIS."

BY J. D. THOMAS, M.D.,
Professor Genito-Urinary and Venereal Diseases, Western Pennsylvania Medical College.

AS late syphilitic disease of the epididymis, unassociated with disease of the testicle proper, is not often encountered, and in most works devoted to syphilis not even mentioned, I take pleasure in reporting the following case which presented itself at my office on February 1st of the present year:

W. J. M., aged 32 years, a fine-looking and intelligent man, born in Wales, had always enjoyed good general health. He entered the British navy when twenty years of age, where he remained for seven years, since which time he has travelled a good deal. He is unable, owing to his long absence from home, to give a very good account of

his family history, but knows that his father died from some chronic pulmonary trouble. Since leaving the navy he has followed the occupation of a machinist. Two years before leaving the navy he contracted a chancre which was followed by secondary symptoms. He was treated by the ship surgeon for a period of eight months, taking, he says, mercury and potash. For three years following the initial lesion he was troubled occasionally with mucous patches in his mouth. Three years ago a swelling or sore appeared on the anterior and inner aspect of the left leg at the upper part of the middle third. For this he consulted a physician in Cleveland who pronounced it eczema and prescribed a zinc ointment. As the ointment made the leg worse the patient became disgusted and resorted to patent medicines, of which he consumed, he says, large quantities. The sore, however, continued to increase and did not heal for two years—the healing finally taking place under the use of some proprietary salve. The scar remaining is an irregular oval one in outline, and measures 2x2½ inches; the centre of this scar is now becoming white.

About six months ago he noticed an enlargement in the right scrotum, but as it was painless and had not troubled him before he gave it very little attention until he observed that it was gradually enlarging, when he consulted several physicians. As no impression had been made upon the enlargement by treatment, he feared that it might be malignant in its character, and had so arranged his affairs that he could go into the hospital and have the offending testicle removed immediately.

On examination I found two growths, one as large as an English walnut, the other as large as a pea, occupying the region of the globus major of the right epididymis, but distinctly unconnected with the testicle. The growths were close to each other but apparently separate; they were nearly round in contour, smooth, and manipulation caused no pain.

The left side of the scrotum was normal.

The only question that arose in my mind was: Is this a tubercular testicle or is it a syphilitic one? The epididymis is a common seat of tubercular disease, but a very exceptional one for syphilitic disease at so late a date. There was an undoubted history of syphilis and probably one of tuberculosis, the patient himself, however, presenting no other evidence, admitting the enlargement to be evidence, of tuberculosis.

I dissuaded the patient from having his testicle removed immediately, and succeeded in having him take advantage of the doubt that could be settled before long by medication, promising that if no improvement took place I would willingly remove the organ.

The patient was placed upon a saturated solution of iodide of potassium, ten drops three times a day, the dose to be increased one drop

every succeeding day. In addition a mild mercurial ointment was to be used locally.

In order not to be tedious, I will only quote extracts here and there from my notes.

February 28th. Large tumor decreased one-half, small one barely perceptible. Patient taking at present forty grains of the iodide three times a day and experiences no discomfort from the dose. Instructed not to further increase dose.

March 7th. Improvement continues. The swelling is not discernible by ocular observation alone.

May 11th. To the touch the enlargement has dwindled to one small nodule.

June 7th. Careful manipulation reveals an induration, but it is oblong. Patient still taking forty grains of the iodide three times a day and desires to continue the dose as he claims that under its use he feels excellent; he is, however, instructed to decrease the dose.

The improvement under the use of the iodide was so marked and prompt that the diagnosis soon ceased to be in doubt. Absorption of the neoplasms was at first rapid, later less rapid, until nothing was left but a small induration. In all probability this small induration will not wholly disappear, for in all likelihood it is fibrous in its nature, the gummatous material having been completely absorbed.

I believe that testicles are often unnecessarily sacrificed. Where in *doubt* it is only just that the patient should have the benefit. In the present case the disease simulated tuberculosis and the patient was anxious to have the gland removed; added to this there was a family history of tuberculosis. One's anxiety to operate often leads his judgment astray.

PITTSBURGH, June 8th, 1891.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

208TH REGULAR MEETING.

DR. E. B. BRONSON, *President, in the Chair.*

Electroplaters' Eczema.—Presented by DR. ALLEN.

DR. MORROW said that the diagnosis was unquestionable, but he was disposed to doubt the patient's statement regarding the transference of the eruption from one part of the body to another by simple contact.

DR. ELLIOT did not think these cases were so very rare. He had had quite a number of such under treatment during the past winter, and could recall particularly several caused by chromate of ammonia. The eruption

in these was caused on the hands by the solution of the chemical, but on the face by the fumes. He had also seen a workman in a Paris-green factory, with large pustular and ulcerating lesions over the hands, which had been caused by the arsenic contained in the substance. In addition, there were on the penis and scrotum, lesions which bore a marked resemblance to mucous patches. Their origin was ascribed to the fact that in urinating he would hold the penis in the hand on which the Paris-green was. The patient also stated that all the men in the factory had similar lesions on the penis and scrotum obtained in the same manner.

Case for Diagnosis.—Presented by DR. A. R. ROBINSON.

The case had been seen by him for the first time on the evening of the meeting. The patient stated that the eruption began on the forearms, and extended over the entire body. No itching or fever had been present. The lesions had remained without change since their first appearance.

DR. BULKLEY thought that in addition to a macular syphilide, there was present also a true multiple erythema produced possibly by the influence of the syphilitic poison upon the nervous system.

DR. LUSTGARTEN said the patient undoubtedly had two diseases, but whether the erythema was connected in any manner with the syphilis it was difficult to decide. He did not think the former disease a true erythema multiforme but rather an erythema urticans.

DR. FOX said the eruption seemed to him a typical erythema multiforme. He had observed erythema multiforme in both early and late syphilis as a result of the pathological process, or of the medication employed.

There was nothing to diagnosticate it from an ordinary erythema multiforme occurring in non-syphilitic individuals. He had seen similar eruptions in patients with gonorrhœa who were taking copaiba. He had noted its occurrence in syphilis so many times, however, that he thought it had some other connection with the disease than as a simple coincidence.

DR. KLOTZ thought the unusual feature of the case was the long duration of the eruption, and he said that it might be explained by supposing that the syphilitic eruption occupied the parts in which the erythema had been originally located, perpetuating the form of the erythema.

DR. TAYLOR had not seen the case. He has observed, however, in the first year of syphilis, the coincidence of multiple erythema with the syphilitic eruptions. A number of writers had discussed the subject. He believed the neurotic erythema nodosum, which he had described, belonged to the same class.

DR. KEYES' impression was that the eruption was due to the influence of the syphilis. The patient stated that the eruption appeared before he took any medicine. It could not, therefore, be a medicinal rash. It was certainly very different from the ordinary syphilitic roseola.

DR. ALLEN believed that everything was possible in syphilis and thought it fair to presume, other things being equal, that the eruption under discussion had something to do with that disease. He recalled a case which he had presented at a former meeting of the society, in which ringed erythematous lesions were present in a syphilitic patient.

DR. BRONSON thought it important to distinguish the pathognomonic from the accidental manifestations of the disease. In this case, he considered the erythema simply an incident in the disease, and that it might be produced by rheumatism or other causes as well as by syphilis.

DR. TAYLOR added that such unusual eruptions in syphilis might perhaps be explained by the hypothesis lately advanced by Finger, that certain manifestations of the disease are due to the direct action of a micro-organism, while others are due to the action of a ptomaine generated within the system. This, however, was hypothesis pure and simple.

DR. ROBINSON, in closing the discussion, agreed with the majority of the members in considering the eruption dependent upon the action of the syphilitic poison on the nervous system. He could see no good reason for not calling the eruption an erythema multiforme, as that affection was not an entity, but occurred in connection with a variety of diseases, as septicæmia, etc.

Rotheln.—Presented by DR. ROBINSON. The patient was a young man in whom the eruption was quite widely distributed. There was a slight conjunctivitis.

DR. SHERWELL had had quite a favorable opportunity for watching two epidemics of rötheln, beside sporadic cases at other times; during this present one he has seen many cases. The roseola was a little different from former times; it looked almost scarlatinoid as a rule. Dr. Robinson's case was a good example, and appeared to invade the whole body and limbs simultaneously. In contradiction to an observation of Dr. Allen's, he would say that he believed a re-infection of measles was extremely rare. Most of the cases so claimed in his experience, and they had been sufficiently frequent, had been in persons of young men who had been using one of the balsams for its specific action; he was not in those cases in the habit of disputing the family diagnosis.

DR. ROBINSON said the appearance of the eruption in rötheln varied in different cases. In this case the eruption was punctate as in scarlet fever.

There were cases in which it was impossible to differentiate the affection from measles or scarlet fever.

Urticaria Pigmentosa in an Adult.—Presented by DR. ELLIOT, with the following history:

Patient, male, age 32 years. Has suffered from chronic constipation and catarrhal gastritis for seven years. Five years ago eruption appeared and has persisted ever since. The lesions are size of small pea, become darkly pigmented and pigmentation remains present for a long time, ultimately fading away. When pigmented spot is rubbed a wheal forms, in a few moments becoming very prominent. Great vaso-motor irritability of the skin, shown by the formation of urticarial wheals on slight rubbing. No itching.

DR. MORROW thought the diagnosis of urticaria pigmentosa a legitimate one, considering the clinical characteristics of the eruption, but the case certainly presented marked differences from the two or three cases of the disease which he had seen, both in the age of the patient, and the appearance of the eruptive features. The lesions in this case were not so large, abundant, nor so deeply pigmented as in the cases he had seen, nor did the pigmentation appear to be so permanent.

DR. FOX said the case presented seemed to be allied to the cases of urticaria pigmentosa that had been presented to this Society by Dr. Morrow, Dr. Goldenberg, and himself. He thought the name misleading, as it had always seemed to him that the pigmented tubercles were the essential feature of the disease and the urticaria a secondary element.

DR. MORROW added that all the lesions in the affection begin as distinct

urticarial wheals. The pigmentation was a secondary process, but a permanent one. The urticarial element, however, was a marked feature of the disease.

DR. ELLIOT said that he had excised a number of the lesions for microscopic examination. Until the result of such an examination was known, the diagnosis of urticaria pigmentosa would only be a provisional one, but clinically he did not know what other diagnosis to make.

Disease of the Nails.—Presented by DR. KLOTZ with the following history:

H. W., German, 26 years, a baker by trade, had an eruption on the forehead, in August, 1890, which he was told was a ringworm. Soon after he began to work as a barkeeper. In September his hands became sore between the fingers, and the nails of the third and fourth fingers of the right hand began to swell. Being told by his employer that this was a common occurrence among those similarly employed, he did not pay much attention and did not seek relief until recently. The distal portions of the nails of the third and fourth fingers of the right hand have now entirely disappeared leaving a rough thickened surface. The remaining portions of the nail, ending in an irregular, broken outline, are partly black, partly of a dark yellow color, and are raised somewhat above the root of the nails; the nails of the other fingers of both hands are all more or less affected, the lateral portions being principally affected. Here the mass of the nail is of a blackish color, with sharply defined outlines and of a brittle structure. Around the base of the nail the skin is not affected except on the third finger of the right hand where a little pus is oozing from underneath. This, however, seems to be a mere complication of recent date, as the skin most of the time has been dry and not swollen. The nails of the toes are not affected. Under the microscope in one specimen nests of rather small spores were seen.

DR. ALLEN said that a similar condition of the nails was seen in bartenders, associated with an eczema of the fingers and pustular lesions of the nails, undermining and destroying them.

DR. TAYLOR looked upon the affection as an eczema complicated by the parasitic trouble.

DR. KLOTZ had noticed black points on the borders of the nails, which recalled like appearances seen by him in parasitic nail affections, which he had cured by chrysarobin in chloroform. The disease appeared to start from the side or from the free margin, and not from the root of the nail, as in eczema.

Lupus Erythematosus of the Face.—Presented by DR. JACKSON in behalf of DR. FOSTER.

Tubercular Syphilide of the Forehead.—Presented by DR. ROBINSON to illustrate the intractability of the case to remedies.

DR. FOX looked upon the eruption as syphilitic.

DR. BULKLEY had seen one or two cases of acute lupus erythematosus of the face resembling this one, and the question arose in his mind as to the possibility of the presence of lupus erythematosus following or occurring in conjunction with the infiltration of syphilis.

DR. ROBINSON said the patient had been under his treatment for eight months, during which time he had given him mixed treatment, and had used mercurial ointment locally. He took iodide of potassium badly. A marked improvement in the patient's condition would take place, but within a few days the disease would recur in the same condition as before.

An œdematous-like condition of the infiltration would occur rapidly and disappear.

Chancre of the Thigh.—Presented by DR. KLOTZ. History of the case is as follows :

O. W., 28 years of age, German, car-driver, presented himself at the Dispensary on May 26th. On examination his entire trunk and part of the extremities was found to be covered with a typical small papular syphilide ; in the left groin the lymphatic glands were enlarged to the size of a goose-egg, without pain or redness of the skin. The penis and the pubic regions were carefully examined, but no lesion of any kind could be there detected. But after removal of a bandage from the left thigh, on the front aspect of the lower third, a primary sore of typical appearance was found. It consisted of a nearly circular, somewhat elevated disk, about the size of a silver half-dollar, slightly indurated, with a dark-red, shiny surface, discharging blood and a thin watery secretion.

The patient reports that he had had no connection with a woman since two months ; that about four weeks ago he noticed a blister on the thigh, which he repeatedly scratched. It did not heal but gradually got larger until it reached its present condition. The swelling in the groin appeared about three weeks ago. No direct explanation of the location of the sore could be elicited from the patient.

DR. TAYLOR referred to a number of cases of the extra-genital location of the initial lesion which he had seen.

DR. FORDYCE spoke of a case of chancre of the thigh which he had seen at Prof. Fournier's clinic in which the infection had been conveyed to the patient while sleeping with a man who had an initial sore on his penis. A previous ulcer on the thigh had received the virus.

Psoriasis Resembling Eczema Seborrhoicum.—Presented by DR. BULKLEY.

The disease affected a man aged 25 years. It began six weeks ago as a papulo-squamous eruption on the chest, afterward extending to the abdomen. The itching had been intense, the scaling moderate. Ointment of sulphur and resorcin was applied and was followed by a diffused general eczema. The inflammation over the legs assumed a purpuric character.

Morphœa on the Abdomen.—Presented by DR. SHERWELL.

The patient was shown to the Society about a year ago, during the acute progress of the disease. He was presented again this evening to show the atrophic changes in the patch.

Atrophy of the Extremities followed by Symmetrical Ulceration of the Legs.—Presented by DR. MORROW.

Patient was aged 47, a native of France. His paternal grandfather and grandmother, his father, mother, uncle and sister, had suffered from a similar affection. In all these cases the disease had begun when the subjects were from 35 to 40 years of age.

In the patient's case the first symptoms of the disease manifested themselves when he was 37 years of age in the form of sensations of heaviness in the legs attended with some difficulty in walking. The ulcerations first appeared three or four years ago ; they healed with rest and treatment in a Paris hospital. The present ulcers developed in May, 1890, and have continued much the same since. They are almost symmetrically seated on the anterior aspect of the middle third of each leg, and surrounded by a band of

redness and pigmentation extending to the ankles. There is marked atrophy of the legs and forearms, with loss of power in the extensors.

Dr. Fordyce thought the case should be investigated from a neurological standpoint, especially in regard to ocular symptoms. The atrophy of the extremities would rather speak against the diagnosis of locomotor ataxia, although the family history would point to the hereditary form of that disease.

DR. MORROW had not yet had an opportunity to thoroughly investigate the case. He had thought of syringo-myelia, but the peculiar sensory disturbances which were characteristic of that disease were not present. Progressive muscular atrophy had also been considered, but in that affection such trophic lesions were not encountered. His opinion was, the case was one of ataxia in which muscular atrophy and peripheral neuritis were present.

Déjérine had found that muscular atrophy occurred in twenty-five per cent of cases of tabes and that peripheral neuritis was common in that affection. In hereditary tabes the ataxic symptoms occur early; in this case, however, they were a late manifestation.

He hoped at a later day to present a more extended report of the case.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

THANKS to the impulse given by the formation of the French Society of Dermatology and Syphilography, the works published upon these subjects in our country have become so many and considerable that it is impossible for me in my quarterly letters to keep the readers of the JOURNAL acquainted with these numerous contributions. I am therefore obliged to limit myself to those which possess for them a certain practical interest.

I ought, in the first place, to mention the appearance of a *new edition of the French translation of the lectures of Kaposi by Messrs. Besnier & Doyon.* This work consists of two magnificent volumes of about 900 pages each. The chief interest of the work is constituted by the numerous notes annexed by the translators, which surpass in importance and value the original text. It is a most conscientious and perfect work which gives a complete picture of the present state of dermatology.

Treatment of Local Tuberculosis by the Injection of Oil of Creasote in Large Doses.—In a previous communication, made the 12th of March, 1891, to the Society of Dermatology, Dr. Burbureaux explained his operative procedure. He injects, on an average, 50 grammes of oil of creasote per day in the subcutaneous cellular tissue of his patients and often increases this dose to 100–180 and even 220 grammes at a single time, representing doses of creasote varying from 3 to 14 grammes, without ever having serious accidents.

The material he uses is rectified creasote, mixed with perfectly pure oil, in the proportion of 1 gramme of creasote to 14 grammes of oil. The creasote should not contain phenic acid; it should be distilled between 200 and 210 degrees; thus prepared it contains chiefly guaico, also a little creasol. As to the oil it should be the oil of sweet almonds hulled, the oil of earth nuts, or olive oil; it is necessary to wash it in alcohol in order to remove the oleic acid, and then drive off the alcohol by decantation and boiling.

This mixture is very well tolerated by the subcutaneous cellular tissue when introduced with extreme slowness: only 20 grammes should be introduced each hour, that is to say, from 2½ to 8 or 9 hours should be employed in making the injection. One is thus obliged to employ a special apparatus, constructed by Dr. Guerden under the directions of Dr. Burbureaux, and which works automatically by the simple pressure of air. For this purpose the air is introduced by a pump into a graduated flask from which it cannot escape, and where it compresses the oil of creasote, which discharges, drop by drop, through a long rubber tube terminating in a needle of gold or platinum with an aluminum mouth. A manometer of compressed air indicates the pressure to which the air introduced in the apparatus is subjected. When the proper pressure measured by the manometer is obtained the needle is introduced into the subcutaneous cellular tissue, after having used all necessary antiseptic precautions. The lock is then opened and the flow takes place regularly without farther necessity of observation. A stroke of the piston every two hours on the average is sufficient to keep up the pressure. When the quantity of the medicine one wishes to inject has penetrated beneath the skin, which may be readily seen as the oil is contained in a graduated glass cylinder, the stop-cock is closed, the needle is allowed to remain two or three minutes in the skin that the equilibrium may be established; then it is withdrawn and the puncture covered with a plaster dipped in an antiseptic solution.

The injection is rarely very painful: the most favorable place for the injection is the region of the buttocks—some patients prefer the back or the external surface of the thighs. They are able to walk about or work as soon as the injection is completed.

During the first half-hour after the injection there is nothing appreciable; then there may be seen at the point of the injection a minute swelling, 5 or 6 centimetres in diameter on the average: in the course of an hour there develops, two times out of ten, a slight erythematous redness. Most often this erythema, as well as the tumefaction, disappears in a few hours and the following morning there is no trace of the injections. One time in ten the injected region is indurated and painful to the touch for several days; one time in 100 the oil is encysted, the region becomes fluctuating and remains so during five, ten or even fifteen days, the cyst always undergoes resorption, it never suppurates.

When the needle is not plunged sufficiently deep the injection is quite painful, the flow of the liquid takes place with difficulty, and there may occur an eschar at the point punctured.

Dr. Burbureaux, following in this the way already opened by Dr. Gimbert (of Cannes), who is the actual originator of this method, has for more than two years employed with success injections of the oil of creasote for the various manifestations of tuberculosis, especially in pulmonary tuberculosis, and in cervical adenitis too voluminous to admit of surgical interference. He proposes to experiment with Dr. Barthélemy in cutaneous tuberculosis.

Dr. E. Besnier immediately began to experiment with this method in his service at the Saint Louis Hospital, and at the meeting of the Society of Dermatology, on the 11th of June, he communicated in part the results of his experiments. According to him lupous tubercles and scrofulo-tubercular gummata are influenced by injections of oil of creasote, moderately in the case of lupus which becomes visibly congested, favorably in the case of open

gummata in which cicatrization has been rendered quite active. The general health seems to be benefited by the injections and to suffer no accidents. Nevertheless, in one patient affected with pulmonary tuberculosis in a torpid form and with tuberculosis of the tongue, he observed, after the eleventh injection, when the ten previous had provoked no accident, a grave syncopal state followed by an intense pulmonary congestion and a serious general condition. The observer believes that these phenomena might be attributed to the penetration of the creasote in the veins; he therefore advises that the needle be disconnected before being introduced in the subcutaneous cellular tissue and not to connect with the tube conducting the oil before being assured that blood does not flow from the canula.

Treatment of Leprosy with Oil of Chaulmoogra and Gynocardic Acid.—I have already, in a previous letter, spoken of the brilliant results obtained by Dr. E. Vidal at the Saint Louis Hospital in the treatment of leprosy by chaulmoogra oil in large doses. Since this substance is not always well supported, it has been replaced by gynocardic acid, which constitutes its active principle. When it is pure and prepared according to the process of Mr. Roux, gynocardic acid has the great advantage of not causing constipation and producing neither malaise nor nausea. One may give doses of 3 grammes per day, which represents 17 grammes of chaulmoogra oil. It may be given in the following forms, from 2 to 5 capsules of 30 centigrammes each before eating, or from 5 to 20 of the following pills a day, before eating :

℞ Gynocardate of magnesia, ...	4 grains
Extract of gentian,.	1 grain

M. ft. pil. xx.

or, again, 10 to 20 capsules each containing 20 centigrammes of gynocardate of soda may be given each day.

Hygiene of Syphilitics.—In an excellent article which appeared in the *Revue Générale de clinique et de Thérapeutique*, Dr. Alexander Renault has exposed the general outlines of the hygienic treatment of primary syphilis. While these may have already been known, it is well to recall them to practitioners who too often imagine that in order to treat a syphilitic, it is only necessary to prescribe for him iodide of potassium and one of the numerous preparations of mercury at present in vogue.

A patient attacked with a syphilitic chancre ought, in the first place, to keep himself perfectly clean. In the case of men it is important that they carefully cleanse the prepuce, the anus, the inguinal regions, the umbilicus, the axillæ, the mouth, the nose, and the ears. Exceeding cleanliness is even more necessary for women, who should at least twice a day wash the genital parts and the utero-cervical canal. The exceeding care in the cleanliness of the person explains why, among prostitutes of high degree, syphilitic lesions of the genitals are so rare, while they are so common among the low prostitutes.

Long walks, jumping, dancing, are not fitting for persons who have a syphilitic chancre, since every friction of the chancre is a cause of irritation, of development of the lesion, sometimes even of suppuration of the inguinal ganglia. If the chancre occupies the urethra it is well to prescribe to the patient abundant drinks and especially soothing drinks, such as tisanes of barley, couch grass, linseed meal, etc.; beer, alcohol, liquors, and wines

should be interdicted. If the chancre is situated about the anus, regularity of the bowels should be maintained by an appropriate regimen: it is necessary in such a case to avoid both constipation and a too frequent action, since both are causes of irritation. Before going to stool the chancre should be covered with a little lanolin or vaselin.

For all chancres of the anus and genital regions frequent bathing should be ordered.

When chancres are situated outside the genital parts it is necessary, first of all, to keep them very clean and to protect them by an impermeable bandage from contact with all external agents; for this purpose I cannot too highly recommend the new plasters of iodoform, of calomel, and especially aristol and salol which are not irritating and have no odor.

When the chancre is situated about the mouth all causes of irritation of the buccal cavity should be avoided with the greatest care. It is of the first importance that the patient should not smoke, should not drink liquors or strong alcoholic beverages, and should avoid all highly seasoned and irritating aliments, etc. I may add that the buccal cavity should be frequently rinsed with a solution of boric acid or of borate of soda.

Prophylaxis of Syphilis for Nurses and Nurslings.—In a paper read March 10th before the Paris Academy of Medicine, Dr. Duvernet, Medical Inspector of Nurses of the Prefecture of Police, has given certain statistical results of his practice for six years. Every year there are made at the Prefecture of Police about 14,000 examinations of nurses, among whom 5,300 bring up nurslings in the family. Each one of these women when she comes to the Prefecture is armed with a certificate given by a physician in her neighborhood and testifying that she is not affected with any contagious disease; but the nurses who quit their place in a family, before taking another place, are obliged to submit to a new visit to the Prefecture. Now Dr. Duvernet complains justly of the insufficiency of this visit so far as relates to the prophylaxis of syphilis.

Practically, when at this visit, the nurse is recognized as a syphilitic, she is interdicted from taking a place as a nurse and is simply informed that she is suffering from a communicable disease, without entering into other details. When she is not manifestly syphilitic, but it is known that she has given the breast to a syphilitic nursling, her examination is adjourned for two months from the day when she was separated from the syphilitic infant. But it is quite certain that very often it is not known whether the women have nursed syphilitic infants. If then they are at the moment of examination free from apparent lesions, they are permitted to take a place and if syphilis afterward breaks out, they may thus prove sources of syphilitic infection.

The author demands that the following administrative regulations should be adopted:

1. All nurses seeking situations who, since less than two months, have given the breast to a nursling, should before being permitted to take a new place, be required to produce a medical certificate testifying that the nursling was not affected with any contagious disease.

2. Any nurse who is not armed with such a certificate must be provided with a medical certificate (the date of which corresponds to a period at least two or three months from the day she separated from her last nursling), testifying that she has not been contaminated by this nursling.

3. Every person who takes a nurse from *Bureau de Placement*, accepts the obligation to procure for this nurse, at the moment she leaves his service, a medical certificate certifying that his child was not affected with any contagious disease.

The Treatment of Grave Forms of Syphilitic Parenchymatous Keratitis.—Dr. Obadie, in a communication made before the French Society of Dermatology, April 4th, has recalled that parenchymatous keratitis is a common affection, that it is especially frequent in adolescents, but it may be observed in children from 8 to 10 years of age; that it may be met with in a very distinct and severe form in persons above 30 years of age; that hereditary syphilis is the principal etiological factor in this affection, and that it is necessary to combat it with an appropriate treatment. Most physicians prescribe mercury and iodide of potassium together in these cases. This, according to the author, is a practice liable to be followed by the most unfortunate consequences. He recommends that subcutaneous injections of sublimate should be made and this alone. He has seen in certain cases, when the iodide was given at the same time, the cornea become extremely vascular and undergo softening. By suppressing the iodide while continuing the injections of the sublimate, these grave accidents disappeared.

Here is his method of making the injections: The syringe is kept constantly plunged in a solution of carbolized glycerin (5 per cent), so that it is perfectly aseptic. He fills 17 divisions of the syringe with a 1-per-cent solution of the sublimate and the three remaining divisions with a 5-per-cent solution of cocaine which markedly lessens the pain.

Abortive Treatment of Blennorhagia.—Prof. Diday, of Lyon, has just given a lecture at the Saint Louis Hospital on the abortive treatment of blennorrhagia. It is necessary to begin it at the earliest possible moment, to use a 5-per-cent solution of nitrate of silver in a small ordinary glass syringe, and introduce into the canal six or seven cubic centimetres of the liquid. The injection made and the syringe withdrawn, the urethra should be closed by applying one finger over the meatus. The liquid should now be pushed from before backward so as to make it penetrate to the fossa navicularis, then from behind forward so to make it act upon the entire spongy portion of the canal: these little manœuvres are readily executed by pressing the canal between the thumb and index finger; then placing the penis in a vertical position it is necessary, after having opened the meatus, to inject between its two sides some drops of the silver solution in order to be certain that it has been thoroughly subjected to the action of the caustic. If the pain experienced by the patient be not too violent, the liquid is allowed to flow out, if not, it is well to leave it in place about two minutes, or even longer if the patient can endure it.

This rapidly develops an intense irritation of the canal characterized by a yellowish discharge, concerning which it is well to forewarn the patient. This discharge continues scarcely 24 or 48 hours, and then entirely disappears if the abortive injection has succeeded; otherwise it will be succeeded by the ordinary discharge of blennorrhagia.

The patient should urinate without forcing the urine. If urination prove difficult it suffices to give him a warm bath, to place hot compresses around the penis, or to give him an injection of oil of sweet almonds. If he cannot urinate, it is necessary to use with the utmost precaution a catheter with a rounded beak.

The patient should not only abstain from coitus, but also from every genesic excitement; the bromides or belladonna may be given for nocturnal pollutions and also a simple regimen.

If toward the fourth day after the injections the characteristic blennorrhagic discharge is seen to reappear, a new abortive injection should not be tried; it is necessary then to have recourse to the ordinary method: let it run and administer the balsamics. L. BROCQ.

PARIS, June 20th, 1891.

Selections.

On the Tendency to Flush as a Cause of Morbid Changes. JONATHAN HUTCHINSON. (*Brit. Jour. of Dermat.*, III., No. 1.)

"Amongst the anatomical regions which in virtue of the special structure and vascular supply are liable to peculiar forms of disease, we must count the middle of the cheeks. In these parts the capillary circulation is very abundant and superficial, and is also liable to remarkably frequent physiological change. It is the part in which blushing begins. It is the part in which exposure to heat and cold are first shown by florid congestion in one case or more or less of lividity in the other. It is the part in which the flush after meals in those who are liable to such flushing usually starts. It might perhaps be a matter of convenience if we were to designate this region as the 'flush-patch.' . . . It is generally recognized as a sign of health that this flush-patch should merge insensibly into the rest of the cheek. When it is abruptly circumscribed the condition is generally indicative of more or less delicacy of organization." With this introduction, the author narrates several cases from his store of rare affections, illustrating diseases of this region which all show some disturbance in the vaso-motor apparatus. For the details of the cases which show, furthermore, the close connection between chilblains, Raynaud's disease, acne rosacea, and lupus erythematosus, the reader is referred to the original. S. POLLITZER.

Acnitis, a Form of General Disseminated Folliculitis and Perifolliculitis. M. BARTHÉLEMY. (*Annales de Dermat. et Syph.*, II., 1.)

Three cases of a hitherto undescribed form of disease occurring, one in the service of Fournier, the other two in that of Besnier, are described by the author under the unhappy and meaningless name of acnitis. The affection begins suddenly, the patients being in good health, and its irruption is not attended by any subjective symptoms. It appears in the form of small nodules, especially about the face and head, but occurring also on the trunk and extremities. These nodules are at first of the size of a millet seed, and are distinctly subcutaneous; they cannot be seen at first, but may be felt on passing the finger over the surface. They are firm, hard, round or oval, may be rolled about between the finger and thumb, and are painless. Gradually the little nodule begins to grow and in the course of ten or twelve days attains the size of a pea. There is now a slight elevation of the surface perceptible, and the skin is slightly reddened. If the nodule is pierced by a knife at this stage, a drop of pus is discharged. If left to itself the skin breaks, and during three or four days there is a slight discharge of pus and sero-pus.

Then a little crust forms; it falls off after about ten days, and there remains a pigmented macule or a cicatrix. Sometimes several of the nodules, situated closely together in a group, constitute at their acme a large boss. The irruption appears in successive crops—twelve to fifteen nodules at a time during the period of activity, later three or four—reaches its maximum intensity in the third or fourth month, then gradually declines, lasting in all some ten or twelve months. Mercury and antiseptics seemed to have no effect on the local process.[1]

The histological examination of a nodule at the height of its development (made by Darier), shows that the lesion consists essentially of tissue of new formation infiltrating the cutis, and situated chiefly around a hair follicle. The new tissue consists: 1, of round lymphoid or embryonal cells, especially abundant near the periphery of the neoplasm; 2, of epithelioid cells; and 3, of giant cells of all sizes, some large and typical, with granular centre and ring of nuclei, others small, resembling epithelioid cells, with many nuclei not arranged peripherally. These latter are giant cells not yet fully developed. The precise point of origin of the new growth could not be determined, but it appeared to be grouped around the lower portion of a hair follicle, and was certainly not associated with the sebaceous glands. Though the affection appeared manifestly of infectious origin—from its anatomical characters—the search for bacilli resulted negatively, and the inoculation of the pus into Guinea-pigs was equally without effect. S. POLLITZER.

A Case of Addison's Disease with Atrophy of the Suprarenal Capsules. FERD. ROLOFF. (*Ziegler's Beiträge z. path. Anat.*, Bd. IX., Hft. 2, p. 329.)

The patient, a phthisical student aged 22 years, presenting the usual signs of Addison's disease, died suddenly in collapse. The autopsy showed tuberculosis of the lungs, and an almost complete atrophy of the suprarenal capsules. The latter showed not the slightest evidence of tubercle past or present. The semilunar ganglion was found to be entirely unchanged. The skin presented the pigment changes usual in this disease. The author could not satisfy himself, however, that the pigment in the cutis lay inclosed in cells. It appeared to be free in lymph-spaces. S. POLLITZER.

Tuberculin in Leprosy.

In considering the effects produced by tuberculin in subjects of lepra, it must be taken into account that many suffer from tuberculosis at the same time, which would explain the reaction, and invalidate conclusions unless carefully excluded beforehand. In some instances the immediate contact of the fluid with the skin in leprosy appears to produce an irritation not noted in the case of healthy skin.

Leprosy of mucous membranes shows often no reaction, while in nerve leprosy there is general and slight local reaction. In a case of lepra maculosa injected by Kaposi, slight fever occurred, and at the same time the lepra patches showed a puffiness, which after the second injection caused them to appear like the lesions of lepra tuberosa. In a second case of lepra there was no reaction.

Arning has carried out some observations on lepra inoculations. In two undoubted and uncomplicated cases, free from a suspicion of tuberculosis,

[1] The Reporter has recently observed a similar case which he expects to have ready soon for publication. S. P.

the inoculations produced absolutely no reaction, either local or general. In one case the dose was increased to six milligrams, and in the other to one centigram.

In a case of leprosy injected by A. Köhler, no reaction followed even when twenty milligrams of fluid were employed.

Professors Babes and Kalendero (*Wiener Med. Presse*, No. 4) give an interesting account of the working of the remedy in lepra. They find that the same, or a larger dose, is required to produce the febrile effect noticed in tuberculosis. In the latter the reaction begins in from six to eight hours, while in lepra fever appears as a rule only after twenty-four hours. The reactionary symptoms are the same in both affections, but, like the fever, last longer in lepra. While in tuberculosis the local reaction appears as a rule coincidently with the elevation of temperature, in lepra it is absent, usually, during the first febrile reaction, and appears sometimes only after several days of treatment. Differing from the local reaction in tuberculosis, in which tubercular products are thrown off, and improvement takes place in nodular or tubercular lepra, the local reaction is at first scarcely noticable, and first appears during the later febrile movements. The reaction consists, then, in sensitiveness, redness, and marked swelling of the leprous infiltration which often simulates a beginning erysipelas. There is often, too, in the parts surrounding the lepra node a more or less intensely red wide zone. After the period of reaction, the leprous infiltration undergoes a diminution and bleaching, as well as a drying process, the surface becoming eroded and covered with larger or smaller dry crusts. In nerve lepra, which shows itself very sensitive to the remedy, there is the same general reaction as in the tubercular form, but the local reaction is often difficult to make out.

In one case there was marked redness of the leprous patches, while aside from this only the successive symptoms of improvement in the general well-being and in the intellect of the patient; the reappearance and even increase of sensation in the anæsthetic patches; the rapid drying up of pemphigoid eruptions, as well as improvement in the movements of atrophic extremities, showed the gradual local effect of the remedy.

These differential characteristics in the reaction show the essential distinctions between lepra and tuberculosis, and place us in a position to decide: 1. Whether in a given case we have to do with lepra or tuberculosis; 2. Whether and when the disease is associated with tuberculosis; 3. Whether or not a suspicious tropho-neurotic affection is of leprous nature.

Drs. Heineman and Jacobi have had under observation in this city, though the courtesy of a colleague, a young man with tubercular leprosy of nine years' duration. Up to the time of this report great improvement had taken place, both in the patient's feelings and in the objective signs.

The anæsthetic areas, which are widely distributed over the body, are regaining a natural sensitiveness. The contractures of the hands and fingers are becoming less and less marked, and the ulcerations have healed.

A case of lepra in the service of the reporter at Charity Hospital, in which the skin lesions had almost wholly disappeared under chaulmoogra oil, was inoculated with 0.001 of tuberculin, on February 6th, a few days before which date a new crop of erythematous blotches had been noticed upon the trunk, with tubercular lesions surrounding the elbows. Result of first inoculation was negative, excepting that patient complained of a peculiar coldness in both arms which he had never before experienced. Both ulnar nerves

are much thickened, and there is marked "bird-claw" deformity of the hands.

One week later a second injection of 0.002 was followed by slight elevation of temperature, lasting for several days, pains in muscles of legs, decrease in tenderness over ulnar nerves, and increase in size of one skin lesion, which swelled up and looked for a time as though it might become a bulla. This condition disappeared in a few days, and the nodule became again firm and flattened. After the third inoculation of three milligrams, patient passed a sleepless night, succeeded by chills and pains in the extremities, with a temperature of 101°. After four milligrams the temperature reached 103.4°, and an urticarial eruption of very bright red lesions appeared on various regions of the body. These lesions were tender, and during the next few days passed through changes of color similar to those seen in erythema nodosum. At the same time the previously existing lepra lesions became brighter in hue and more raised above the surface, and many took on a decided bluish color. During the next few days a marked decrease was noted in the size of the new lesions, which on disappearing left behind macular spots showing a tendency to desquamate. CHARLES W. ALLEN.

Treatment of Condylomata. DR. G. FINCO (*Gazetta Medica Lombaraa*, June 21st, 1890) recommends the following in the treatment of condylomata:

Collodion, ...	2.00 grams.
Mercur. corrosiv., ...	0.02 "

The collodion should be poured into a small cup, the corrosive sublimate added, and the whole well shaken, as the sublimate does not dissolve in collodion.

The largest condylomata may be touched with a small brush dipped into the mixture, following this with the local application of cold water. On the following days the others may be treated until all are removed.

ALBERT PICK (Boston).

The Abortive Treatment of Erysipelas. DR. NATALE AMICI. (*Gazetta Medica di Roma*, No. 3, 1891.)

The writer's method consists in sterilizing the streptococcus of erysipelas in the shortest time possible. Infection is not always limited to the reddened portion of the skin, but is often found beyond this in the latent state, even at the distance of thirty-five to forty centimetres, as the author has been able to undoubtedly prove in erysipelas of the extremities. It is not always easy to decide whether the infection be limited to the reddened skin alone, as is especially the case when the disease is met with at its beginning, or is beyond the boundaries of the inflamed spot. In general one may suspect that the infection has overleaped the apparent limits, if from the first there be symptoms of any gravity, as high fever, headache, burning thirst, and vomiting. Besides these phenomena in such cases the apparently normal skin will be found on pressure to be painful, which pain will be more striking if pressure be made upon the inflamed focus. In other cases isolated inflamed spots, of the size of a franc piece, will be discovered scattered here and there on the surface of the normal skin; these are also sensitive to pressure and already foci of infection. As one withdraws from the central infected and inflamed

spot the cutaneous painfulness on pressure decreases gradually until where it ceases one may assume that healthy skin is reached. Hence, if one would stay the progress of the disease these outrunning points of infection must be sterilized. Therefore this method of abortive treatment consists in carefully recognizing latent infection in order to combat it as quickly as possible. Any suitable antiseptic may be used. The writer employed solutions of carbolic acid and alcohol, carbolic acid and glycerin in equal parts and finally, in those cases where this remedy is not well borne, he recommends the following:

Hydrarg. chlor. corrosiv.,	0.03 grams.
Glycerin,	30.00 "

For external use.

All these three solutions are to be applied locally by means of a small brush. This same treatment is also useful in lymphangitis.

F. H. PRITCHARD.

Urticaria from the Sulphate of Quinine. DR. V. GIAMPETRO. (*Rivista Clinica e Terepeutica*, No. 9, 1890.)

Urticaria is often the consequence of the ingestion of some alimentary as well as medicinal substances. Among the latter are the balsam of copaiva, turpentine, valerian, santonin, and several mineral waters. Dr. Martini has recently reported a case produced by the use of antipyrine, while the writer describes the following observation:

A woman, forty-five years of age, strongly built and well nourished, had been subject for several years, without any discoverable cause, to neuralgic pains in various parts of the body. The pains were especially severe in the regions of the trigeminus, cervico-occipital, cervico-brachial, intercostal, lumbar, and ischiatic nerves, returning after longer or shorter periods of quiet to torment the patient. Various domestic remedies had been used with varying results. The patient coming under the care of the writer he administered, on account of the periodicity of the attacks and a slight rise in temperature accompanying the height of the pain, the sulphate of quinine. Scarcely had the second powder been taken, each one containing fifteen to twenty centigrams, when the patient began to complain of an intense and annoying itching. This was followed by the efflorescence of urticaria, scattered here and there in large and small blotches all over the body, and lasting twenty-four to thirty hours. This same result followed several times the administration of the drug, even if it was given in a small dose. The citrate of quinine, however, was well borne during an attack marked by great severity of the pains and a rise of temperature higher than ever before. One gramme was taken the first day and one and a half the next, which cut short the fever and quieted the neuralgia, without any urticaria making its appearance. The writer thinks that to the action of the acid and not the base of the salt is to be attributed the urticaria. ALBERT PICK (Boston).

Ceresole Reale Water in Diseases of the Skin. DR. F. CERASI. (*Gazetta Medica di Roma*, No. 16, 1890.)

This ferruginous, acidulous, and slightly alkaline mineral water is much used in England, Egypt, Switzerland, and especially in Northern Italy. The spring is situated on the side of Mount Bellaguarda, near the Orco River, on the border between Piedmonte and Savoy, at a height of 1,500 metres in a

forest of pines, firs, and larches. The constituents upon which its therapeutic properties depend are: bicarbonate of iron, free carbonic acid, bicarbonate of manganese, and arsenite of soda, of which, according to the analysis of Prof. Morelli, every litre of the water contains six milligrams. Its action in anæmia, chlorosis, amenorrhœa, cachexias, anæmic neuralgias, etc., has already been studied and successfully experimented with by Bozzolo, Tassinari, and others. The writer then considers the action of the water, respectively, arsenite of soda, in several dermatoses in which the ordinary arsenical preparations are inferior to it either from their inconveniences or from its prompter action. The first case worthy of noting, on account of its rarity and the relatively prompt result obtained, was that of *prurigo neurotica.* The patient was a man in the forties, of excitable temperament, who was also suffering from other nervous trouble; his organs, however, were in good condition.

For several weeks he had been suffering from subcutaneous papules, which were accompanied by an indescribably terrific itching. These were barely visible upon examination, but well recognizable to touch. Scratching caused them to become more prominent and redder, while in some there appeared a blackish scale due to desiccated blood. They were numerous on the thorax, nates and lower extremities, while in other regions of the body they were discrete. The skin in general was rough and thickened, especially on the dorsum of his hands and feet. The hair of his head and body was somewhat thinned; the skin here and there was separated in squamous layers. The writer remarks that this generalized prurigo ferox is by no means common in Italy, while, on the contrary, local pruritus of the genital region, of the dorsum of the hands, of the natal region in children, of the folds of the knee and arm, are quite frequently observed. One bottle of the mineral water taken daily before or during meals, together with tepid amido-alkaline baths produced a cure in six weeks.

Two other cases are also worthy of consideration:

The first was a lady who for several years had been afflicted with hyperidrosis. The perspiration of the axillæ and feet especially was very fœtid; eczema and intertrigo were thereby induced to such a degree as to make walking impossible. The patient was sixty years of age, of a flaccid constitution, and a sufferer from hysteria. That this hyperidrosis was dependent upon a vaso-motor paresis was demonstrated by it disappearing as if by enchantment under the influence of antipyrine and even more promptly after exalgin (60 cgm. per day), to reappear a short time after. It was especially troublesome during the colder seasons of the year.

The second was also that of a lady, with lichen pilaris limited to the lower extremities. The disease had already existed for several months, and obstinately resisted every system of treatment. The patient was of a herpetic diathesis. This had manifested itself several times, each time to be followed by a period of quiet. The disease on awakening from its latency was accompanied by epileptoid convulsions, becoming after each period more and more aggravated in form and extension.

In both patients the prolonged use for two to three months of the water internally, with local application of compresses to the parts affected and cold baths, induced a cure.

The writer considered the disease in all three of these cases as either directly or indirectly due to nervous disturbances of the skin. In all the

cases in which he used the water, he never has observed any symptoms of arsenicism as conjunctivitis, dryness of the throat and fauces, or symptoms of gastro-enteric or renal irritation. Under the use of the remedy the red blood-corpuscles and blood take on a more intense color, which goes to confirm the results of the experiments of Schmidt and Bretschneider, with regard to the blood of individuals undergoing treatment with arsenic. The increase of the body in weight, accompanied by the diminution of urea and the greater vigor and muscular power, which commenced after about a week and progressed gradually, were indicative of a diminution in the process of oxidation and the production of sarcolactic acid. Finally, the author would regard the arsenite of soda as one of the principal means at our disposal to combat dermatoses due to altered nervous action, as it favorably influences the histological elements of the skin, arrests the process of oxidation, improves the condition of the blood, and invigorates all the organic functions. The writer also employed the water successfully in two cases of scrofuloderma. The one patient, a young girl, suffered from scrofulosis with all the ordinary clinical features of the torpid form of the disease, with suppurating submaxillary glands. The other, also a young female, presented an irregular lardaceous ulcer of the left submaxillary gland, which secreted a fœtid pus. After a few months, use of the water their health was much improved, and the local lesions nearly entirely disappeared. F. H. PRITCHARD (Boston).

The Usage of Drying Liniments (Linimenta Exsiccantia) in the Treatment of Skin Diseases. F. J. PICK. (*Arch. f. Dermat. u. Syph.*, 1891, Heft 4.)

The author, recognizing the objectionable features of the gelatin preparations as manifested in their cumbersomeness, the difficulty of application, etc., states that he has for some time sought to remedy these inconveniences and after many trials finally decided that bassorin was the most suitable substance and answered all requirements. His linimentum exsiccans is composed of

Tragacanth, ...	5 grams.
Glycerin, ...	2 "
Aq. destill., ...	100 "

M

Its preparation can be either by means of heat or in the cold. In the latter way, the constituents of the liniment are rubbed up together in a mortar until perfectly smooth and even. It should have a syrupy or lanolin-like consistence. He prefers the preparation to be made by heat, because in this way an absolutely antiseptic application can be obtained.

The liniment can be used in precisely the same way as the gelatin preparations. Rubbed on thinly, it dries and forms a layer over the skin which can be easily removed by water. Drugs in any amount may be incorporated with it, those soluble in water as well as those insoluble, without altering the characteristics of the liniment. The oily substances do not change its consistence, but in high percentages delay the drying of the application. This was observed by him to occur in the case of ol. fagi, rusci, cadini, ichthyol, when mixed in the strength of 5 to 10 per cent. Substances insoluble in water, as chrysarobin, zinc oxide, etc., gave a pasty consistency to the liniment, without, however, injuring its properties.

He states that the effect of the preparation upon disease is excellent,

though he reserves extended consideration of this portion of the question for another time.

[Attention should be called to the fact that Prof. Pick states that in bassorin he has found the suitable substance, in the preparation of his liniment, however, he uses tra gacanth. The two are by no means identical, though the latter contains, in common with all other vegetable gums, a certain proportion of bassorin (*vide* Dr. F. Foster's Medical Dictionary), and from my own experience and experiments this substance does not adhere to the skin when used in the form of a liniment or a paste. The bassorin is, in other words, a derivative from gum tragacanth, but not the gum itself, as one would be led to infer from Dr. Pick's paper. In this connection, I would also recall that some months ago I directed attention to a bassorin paste to be used as a base for dermatological preparations (JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, Feb., 1891). It was composed of *bassorin* derived from gum tragacanth, glycerin, water, and dextrin, the latter being added in order to make it adhere to the skin. Its characteristics, peculiarities, and properties are exactly the same as those of the linimentum exsiccans of Pick, though it is freely granted that the latter offers advantages over the former, in the ease in which its constituent materials can be obtained and the preparation made. Whether it possesses further advantages must, however, be judged from experimental use, and in that regard the question must be left open.—G. T. E.] GEORGE T. ELLIOT.

Consideration of Certain New Remedies employed in the Treatment of Cutaneous Affections, Particularly as Substitutes for Iodoform. E. CHATELAIN. (*Journ. d. Maladies Cutan. et Syph.*, June, 1891.)

Chatelain discusses the objectionable characteristics of iodoform and then reviews the literature of aristol, bromol, cresalol, eugenol, iodol, lysol, camphorated naphthol, retinol, salol and camphorated salol, sozoiodol, and eulyptol.

Among these aristol is perhaps the most important. Chatelain himself found it useful in varicose ulcers; in syphilitic chancre the effect was not more rapid than iodoform, but in a case of eroded papules of the glans penis he obtained a cure with it in a few days. He experienced a complete failure with it in a case of ulcerating epithelioma of the face, which had first been treated surgically by himself. He was obliged, in order to obtain healing, to have recourse to iodoform.

The various observers who have recorded their opinions find that aristol is valuable in syphilitic ulcerations of all kinds. Some speak favorably of its use in chancroids, others, however, the opposite. The majority have obtained good results with it in suppurating buboes, psoriasis, lupus, and eczema, still there are some who obtained the opposite. The same conclusions are also recorded in connection with epithelioma. The author concludes that aristol is worthy of being retained among dermotherapeutical agents and may prove to be, in the end, a precious successor and substitute for iodoform.

Among the others eugenol may be mentioned, an oleaginous liquid obtained from cloves, insoluble in water, but soluble in alcohol and in ether. Unna found that it destroyed lupus nodules without pain; Leubuscher used a 70 per cent ungt. on a case of very pruritic, weeping eczema with immediate removal of symptoms.

The author also obtained excellent results from the use of iodol in

10 cases of ulcerating gummata. In 20 cases of chancroids the action of the drug was favorable, but it was less than iodoform.

According to the reports, camphorated naphthol has acted well in ulcerations of various nature, in buccal tuberculosis, and also in mycosis fungoides. Nélaton claims that in 27 cases in which he injected into tubercular glands from 7 to 8 drops, a cure was obtained in 21. On the other hand, another observer reports no results from the drug in a case of cutaneous tuberculosis with maxillary and inguinal adenitis. GEORGE T. ELLIOTT.

The use of Tuberculin in the Treatment of Lupus, and also some New Agents in the Therapy of Lupus. P. G. UNNA. (*Monatsh. f. prak. Dermat.*, No. 8, 1891.)

Attention should be directed more especially to the new agents in the therapy of lupus than to the results obtained by Unna from tuberculin. The former are divided by him into two groups according to whether they were painful or painless in their use.

1. Liquefied acid. carbolicum. Pure carbolic acid painted on lupus is a curative agent of the first order. It produces severe pain, but of short duration, and brings to view even the smallest tubercules. It causes coagulation of the albuminoidal constituents of the horny layer, and the membrane thus formed remains adherent. If, after two to four applications, this crust is allowed to fall off, a surprising improvement in the lupus is found to have taken place. Care must, however, be taken against carbolic urine, etc.

2. Ortho-, meta- and parakresole act in the same manner as concentrated carbolic acid, but offer no advantages over it.

3. Creosote obtained from coal-tar has substantially the same action as the other phenols.

4. Beechwood creosote is not as painful as the phenols, but the cure of the lupus nodules is not so thorough as with the latter. It is superior to the others, however, in that it is harmless and can be used by the patient himself.

SUBSTANCES PAINLESS IN THEIR ACTION. 1. Anilin oil. This substance is particularly beneficial for the purpose of rendering lupus surfaces transparent, and as no coagulation ensues, the individual tubercles can be destroyed one after another with the micropaquelin. It is painless in application and if the phenols are added to it the pain consequent upon the use of the latter is also greatly diminished, but at the same time their deeper action and destructive influence on the lupus nodules is also lessened. Still a mixture of carbolic acid, two parts, to anilin oil, one part, possesses all the advantageous properties of the acid alone. Anilin oil itself, when used in sufficient quantity, will also destroy lupus nodules, but its application is not advisable, owing to its poisonous properties.

2. Oil of cloves. Relatively speaking a harmless remedy, it can be applied to lupus, rendering the surface transparent and causing the tubercles to swell up and project above the surface. It causes suppuration of the lupus tubercle without pain, but as it attacks also the healthy tissue and that surrounding the tubercle, its use should be discontinued after its effect on the diseased tissue has been produced.

3. Lysol acts slowly on the tubercles and demands further trial.

Camphor has also valuable properties in the treatment of lupus. He has used it pure, or in a paste with oil of cloves, or in the form of "*Salbenmull*"

and in combination with chloral. It prevents and removes inflammatory symptoms: it cleans the surface on which suppuration has been produced by other agents; it has excessive keratoplastic action; it is not only painless, but pain-quieting, especially when combined with chloral, and finally in concentrated form appears to have a destructive effect on the lupus tubercles. Camphor is particularly good for the after-treatment of a lupus to which carbolic acid of or oil cloves has been applied. GEORGE T. ELLIOTT.

Syphilitic Arteritis. DR. PAUL LE ROUX. (*The Dublin Journal of Medical Science*, June, 1891.)

The author believes that although cerebral arteritis appears to be rare, it is in reality not so, if we consider the number of cases in hospital practice and those revealed by post-mortem examinations. In the first stage it is regarded as curable. Two classes of symptoms are met with: First, symptoms which appear from the commencement, when the artery attacked is simply narrowed in calibre and the blood has some difficulty in flowing through the vessel. Second, the symptoms appearing later when the artery is completely obliterated and the blood is thus cut off from the vessel, and unable to carry life to that part of the brain for which it was intended.

Cephalalgia, occupying the frontal, rarely the occipital, and never the temporal region, which renders all movement painful, diminished vision, dulled intellect, depression, gloomy and apathetic feelings, and sleep attended with nightmare are some of the prominent symptoms. Exhaustion going into syncope, loss of consciousness, nausea, slow pulse, vertigo, cerebral amnesia, and intelligence diminished to such a degree that work must be given up, are among others observed. Cold or other external influences are necessary to bring on the symptoms in certain individuals.

Paralytic phenomena follow these evidences of difficult circulation in the brain. Hemiplegia usually comes on gradually and the patient feels the attack coming. That of the face is more often crossed than direct. The uvula is deviated, which shows that the nerve is attacked before it emerges from the aqueduct of Fallopius. Since the symptoms caused by an arteritis are liable to disappear, a hemiplegia can get entirely well, but once the artery is completely obliterated all efforts to cure are useless.

As regards the diagnosis between syphilitic arteritis, atheroma, tuberculosis, etc., an attentive examination will show that an arterio-sclerosis is never localized in one artery—the entire vascular system being invaded.

Tuberculosis resembles syphilis in certain ways, but it only rarely attacks small arteries and especially the cerebral arteries, and cerebral tuberculosis is nearly always a disease of infancy.

A symptom of arteritis, to which too little attention has been called, in the author's opinion, is cyanosis. Several cases are cited in illustration.

In one there was cyanosis of the leg and foot with increased perspiration when the patient stood up. When cyanosis occupies one side of the face or neck it should be of great assistance in the diagnosis of cerebral arteritis. The Sylvian arteries and the basilar runk, and sometimes also the small terminal intracranial arteries, are designated as among the points attacked by cerebral syphilis. A circumscribed lesion, formed of cells and spherical nuclei, limited to one spot, is characteristic of the tertiary period of syphilis.

It appears to the author difficult for the time being to admit the specificity

of the Lustgarten bacillus. As to treatment, cerebral syphilis should be vigorously treated the moment the diagnosis has been made, as soon as the persistent nocturnal headache or the different troubles of the intelligence are present. If disorganization has taken place it is too late. Iodide should be given by the mouth, in case of complete intolerance by the rectum, and progressively increased from three to eight grammes in the twenty-four hours, administered in some water, beer, or soup, and taken in several doses at the commencement or middle of the meal.

The green iodide of mercury in ten to twenty centigram dose, the bichloride from two to five centigrams, or calomel in fractional doses over a period of four days may be given by Hillairet's method, as follows:

1st day, ...	25 centigrams.
2d day, ...	50 "
3d day, ...	75 "
4th day, ...	1 gram.

Each daily dose should be divided into ten parts. After this the medicine must be stopped for a week and then recommenced. It is recommended to alternate mercurial frictions with iodide of potassium, giving a three weeks' course of each. Treatment should be continued until all symptoms have disappeared and the patient then advised to take several subsequent courses of mercurial treatment, and to take iodide for some years.

A number of clinical histories completes the paper.

CHARLES W. ALLEN.

Syphilis of Abnormal Evolution. DR. DU CASTEL. (*Annales de Dermat. et de Syph.*, May 25th, 1891.)

A case of syphilis was presented before the society with a history of having entered the hospital on account of a vaginitis and ulcerations of the vulva and anus having all the characteristics of simple chancres in course of healing. Shortly after the patient was taken down with typhoid fever and when convalescent contracted scabies. Frictions of styrax ointment were made and within a few days pustules of ecthyma formed on the arms and were soon succeeded by ulcerations which were absolutely chancre-like, having a deep red color, indurated base, etc. There were two on the left arm and four on the right. A few days later there was painful lymphangitis and slight swelling of the axillary glands. Three weeks later there was decided headache and in eight days more a well-marked roseola. The question is whether the syphilis was contracted before entering the hospital and the retarded evolution was due to the typhoid fever, or were the lesions on the arms multiple chancres contracted in the hospital?

Dr. Vidal thought the lesions had been those of chancre—like ecthyma, such as has been called syphilitic ecthyma.

Dr. Fournier had believed them to be syphilitic chancres and regarded the subsequent evolution of the disease with the roseola appearing a month later as confirmatory of this diagnosis. A similar case had occurred in his service at the St. Louis where a patient, who had entered for an eczema consecutive to a treatment for scabies, contracted syphilitic chancres of the forearm.

Dr. Besnier thought the lesions those of secondary syphilis, which had been modified by the itch.

Dr. Fournier pointed out that this would make the appearance of the roseola subsequent to the cutaneous plaques, which is rare. [Though the question is left unsettled, it has its points of interest. What will strike the average reader is the peculiar danger from hospitalism in the French capital, when a girl who enters with a simple vaginitis has her stay prolonged by contracting typhoid fever, the itch, and possibly syphilis.] CHARLES W. ALLEN.

The Curability of Parrot's Disease. DR. COMBY. (*Annales de Dermat. et de Syph.*, No. 5, 1891.)

The author has observed complete cure in three cases of syphilitic pseudo-paralysis. Parrot regarded the prognosis as fatal because he observed the disease in the hospital, where for the most part the children are cachectic and subjected to artificial nourishment. Cure is thought to be possible under two conditions: First, that they are surrounded by good hygienic conditions and are in good condition of general health, and second, that the treatment be instituted rapidly, that is to say, that the diagnosis be made as early as possible. To make the diagnosis it is not necessary that the child present other manifestations of syphilis, since those under consideration are so characteristic. CHARLES W. ALLEN.

The Administration of Mercury to Syphilitic Infants. DR. SIMON. (*Journal des Maladies Cutanées et Syph.*, No. 5, 1891.)

For an infant of five or six weeks the liquor of Van Swieten is considered preferable to other preparations, in the dose of fifteen to twenty drops per day, taken in three or four divided doses. Mercurial frictions can be applied at the same time in the arm pits.

The following formula is given:

Neapolitan ointment, ...	2 grams.
Lanolin, ...	6 grams.

Mix and divide into six doses.

Each dose being wrapped separately in paraffin paper, according to Widerhofer's plan. Each day one is used for a friction in the axilla, and after from two to four days a tepid bath is given.

Widerhofer also employs the following ointment upon the sides of the nose:

Red precipitate, ...	0.10 centigrams.
Lanolin, ...	10. grams.

This is to be applied by mild frictions in quantity equal to that of a pea. This mode of application has the advantages of diminishing the swelling of the mucous membrane of the nose, when it exists, thus permitting the infant to take the breast more readily.

Corrosive sublimate baths are useful, especially in rebellious cases which do not give way to the means above referred to. They must be repeated every three days, and, during the immersion care must be taken to prevent the infants from swallowing any of the toxic fluid.

The following is the formula for each bath:

Corrosive sublimate, ...	0.20 centigrams.
Hydrochlorate of ammonia, . . .	1.00 gram.
Distilled water, ...	120. grams.

If the infant is over six months of age, and is raised on the bottle, the milk can have Gibert's syrup added to it, a third of a teaspoonful in divided doses during the twenty-four hours. The author administers a potion of which each teaspoonful contains one centigram of mercurial salt and half a centigram of the iodide of potassium or sodium.

The following formula can be advantageously employed:

Biniodide of mercury,	. . . . .	0.10 centigrams.
Iodide of sodium,		
Distilled water,	. . . . . āā	1.00 gram.
Syrup,	. . . . .	10. grams.

This is to be given according to the age of the infant, a dose of half a teaspoonful for an infant of one year, a teaspoonful for a child of two to three years, two teaspoonfuls for a child of from three to five years, and three teaspoonfuls for a child of five to eight years. CHARLES W. ALLEN.

Pigmentary Syphilides. DR. FIREISKY. (*Annales de Dermat. et de Syph.*, No. 5, 1891.)

After a study, extending over several years, the author concludes:

1. That syphilitic pigmentations show themselves in the secondary period and occupy in preference the neck and occasionally other regions.
2. Leucoderma in its typical form is always specific.
3. At times it coexists with gummata.
4. They may remain for several years and can be considered one of the best signs of the secondary period.
5. They are more frequent in women, but the generalized forms are more frequent in men.
6. They appear in the third month in forty per cent, in the fourth in twenty per cent, in the fifth in twenty per cent, and in second half of the first year in twenty per cent.
7. They persist usually from one to seven years.
8. Mercury and iodide do not influence them in any great degree, but they are not well marked excepting in the cases where mercury has not been employed at all or only in an insufficient manner.
9. The later they appear the less prominent they are.
10. Three forms can be described: the marbled pigmentation, the spotted, and the retiform. CHARLES W. ALLEN.

Purpura due to the Diplococcus Pneumoniæ. PAUL CLAISSE. (*Arch. de Méd. Expérim.*, III., No. 3, p. 379.)

From the time of the first observations by Klebs and by Hayem on purpura due to bacilli sixteen years ago to the present time, there has been a constantly increasing number of organisms which have been shown by many observers to stand in a causal relation to this affection. Most of these have been organisms already well known, such as the streptococcus and staphylococcus pyogenes; in other cases a special organism has been found. Among the latter the best characterized and most clearly demonstrated new germs are the bacillus of Letzerich ("Untersuchungen über die Aetiologie u. d. Kenntniss der Purp. haem.," 1890), and that of Tizzoni and Giovanni (*Ziegler's Beiträge*, VII.) The author adds to this already large list of purpura-

producers the diplococcus pneumoniæ Fraenkel. The patient, a young man, affected with an old rheumatic endocarditis, entered the hospital with signs of an acute nephritis, a fresh endocarditis, and purpuric patches on his extremities. After a few days lobar pneumonia developed and led to death in forty-eight hours. The endocardial vegetations, the kidneys, the spleen, the lungs, and the cutaneous petechiæ contained the pneumococcus. Similar observations of extra-pulmonary pneumococcus lesions preceding the pneumonia itself have been made frequently before. S. POLLITZER.

Why Syphilis is not Aborted by the Early Destruction or Excision of its Initial Lesions. DR. R. W. TAYLOR. (*Medical Record*, July 4th, 1891.)

This is the title of an essay presented at a recent meeting of the New York Academy of Medicine to illustrate the author's views on the utter futility of excision of the chancre as a prophylactic measure, and to show from histological investigation, carried on by himself and Dr. Van Gieson, why the operation must of necessity result in failure.

Two of the author's own quite numerous cases are quoted in which the excision was followed by secondary symptoms after the usual manner. In one the operation was practised the same day on which the sore was discovered and twenty days after the suspected coitus. The excision was done with stringent precautions to make it thorough. The wound healed in ten days. Induration of the inguinal ganglia commenced and was typical in extent and hardness thirty days after the operation. Forty-two days from the discovery of the chancre, general symptoms were manifest. In the second case a sore, which had appeared seventeen days after coitus, was excised the day after its discovery by a liberal elliptical incision which removed a piece of skin half an inch wide and three-quarters of an inch long. Twenty days after the operation inguinal adenopathy could be made out, and fifty-two days after the first appearance of the chancre well marked secondary manifestations were observed. These, and many other cases with like result, convinced the author that even with the most painstaking, early, and generous excision, syphilis cannot be suppressed or aborted.

A third case, and the one on which the histological studies were made and the conclusions based, concerned a chancre situated upon an elongated prepuce which the author removed to the extent of one and a half inches, four days after the appearance of the lesion, and eighteen after infection. The examination of this specimen showed a circumscribed mass of tissue resembling ordinary granulation, about an eighth of an inch in diameter, in the upper layers of the skin. On either side of this lesion, for a considerable distance, the blood-vessels are uniformly and universally changed by distention of the perivascular spaces with small round cells. The endothelial cells lining the arteries and veins are also swollen and seem to be proliferating, thrombi being produced in the lumen of some medium-sized veins. It is thought that the perivascular cell clusters are produced by the proliferation of the connective-tissue cells of the adentitia of the vessels or of those just exterior to the adventitia. These cells can be traced for a considerable distance from the ulcer. The extremely early and far-extending involvement of the blood-vessels is noteworthy and would seem to have begun before the appearance of the sore.

The microscopical preparations, which are reproduced, show the morbid

process going on at the distance of nearly an inch from the chancre in skin, which to the naked eye looked perfectly normal. These studies, the author believes, warrant the conclusion that the virus is not localized at its point of entry and that it does not shut itself in by throwing out a dense wall of circumvallation, which later on disappears and allows of the exudation of the morbid products. Hence it appears futile to rely on excision after the chancre has shown itself, for in the first period of incubation the infection is going on rapidly by diffusion. In support of this view Külneff's observations on the lymphatic cord in syphilis are quoted and the conclusion is thought to be warranted that the changes which take place in the chancre and small radical vessels run up quite promptly to the larger efferent vessels and largely through them the poison is carried into the system. Thus it is believed that the initial lesion may be removed without altering or modifying the subsequent course of the disease, since beyond the boundaries of the chancre there is sufficient poison to infect the whole economy. As to the effect of these observations upon the method of treatment, the author states that he is as yet unsettled in his mind regarding the advisability of instituting treatment as soon as the first appearance of the chancre has been positively made out.

Treatment of Alopecia Areata. DR. MOTY. (*Annales de Dermat. et de Syph.*, No. 5, 1891.)

At a recent meeting of the *Société de Dermatologie, et Syphiligraphie* in Paris, Dr. Moty presented patients and described a new treatment for alopecia areata, for which he claims superior advantages. This consists in the intradermic injection of corrosive sublimate, two to five hundred. The injections are made around each plaque, each injection being of five to six drops only. Aqueous solutions have been found best and no nodes follow when water is used as a vehicle.

The results are said to be very satisfactory, and the regrowth of hair to be more rapid than after other modes of treatment. CHARLES W. ALLEN.

Cerebral Syphilis. DRS. JAMIN AND DUBOYS DE LAVIGERIE. (*Journal des Maladies Cutanées*, No. 5, 1891).

A patient, thirty-one years of age, presented himself at the clinic with the statement that only since morning had he become almost paralyzed on one side of the body. He stated that three years ago he had a syphilitic chancre. A record of his treatment at this time was found in the clinic books. After four months patient left Paris, but continued to take mercurial pills of one centigram each whenever any symptoms presented themselves. Patient estimates that during the three years he took not less than 1,500 to 2,000 of these pills.

Scarcely two years from the date of the chancre the patient married. The wife remained free from any sign of infection, and bore a strong child at term who showed no signs of syphilis either at birth or since. For nearly a month the patient had complained of intense and continuous headaches, principally in the occipital region and the back of the neck, growing so much worse each night that sleep was almost prevented.

The morning of his visit he had noticed on rising that his left arm and leg could be moved only with difficulty. Speech was embarrassed, the left

angle of the mouth drooped, and the lid of the left eye did not close well the tongue deviated to the right.

Treatment by daily friction of six grams of mercurial ointment and iodide of potassium in daily dose of two grams, increased by one gram every second day. After three or four days the headache entirely disappeared and sleep returned, but patient now complained of seeing objects double.

A paralysis of the external rectus muscle of the right eye was discovered. This gradually improved and the diplopia was almost entirely gone in less than two months. Dr. Jullien has thought he could conclude, from the analysis of many special observations, that the exaggeration of mercurial treatment was perhaps not innocent of the production of these cerebral and medullary accidents in syphilitics.

It is to be noted that this patient took from fifteen to twenty grams of sublimate, and a point which the author thinks more important, during these three years he did not take any iodide of potassium. This case confirms Fournier's statement that the ocular paralyses of syphilitic origin, almost always incomplete, only get well under specific treatment, while the paralyses of locomotor ataxia, which are complete from the first, almost always get well spontaneously. The specific form is generally very tenacious and requires active treatment to make it disappear.

In 1874, Dr. Jullien published a statistical study establishing the fact that cerebral syphilis seemed to be more frequent in patients who had been subjected to a precocious mercurial treatment. A Russian physician, Dr. Watroszewsky, has even recently gone so far as to pretend that mercury placed the organism in such a condition as to render the elimination of the virulent agent of syphilis impossible and rather favored its diffusion. Jullien does not share such an extreme opinion, still it is in the category of patients who have been actively treated, that Fournier has found the elements of his remarkable works on cerebral syphilis.

As to the escape of the child, Jullien firmly believes that it is usually the case when the mother has not been contaminated. Transmission of hereditary syphilis to the embryo by the sperm, that is to say, by the father alone, is altogether rare.

Dr. Dubuc does not believe that mercurial treatment, employed at the beginning of the disease in large doses and long continued, predisposes to cerebral complications. Besides, he argues, do we not hasten to combat the latter as soon as they are produced, by the immediate renewal of mercurial treatment in one form or another?

Dr. Jamin agrees with Dr. Dubuc that mercurial treatment does not predispose to cerebral manifestations of syphilis. He also is in accord with Dr. Jullien regarding the superiority of calomel injections over all other forms of treatment, its action being more rapid, more complete, and more lasting. Still its use necessitates one or two days' rest which all patients cannot command. According to Jullien, one injection of calomel is superior to twenty of corrosive sublimate. As to excipient, after having tried gum-water, oil, vaselin, and glycerin, he has adopted liquid vaselin. With oil, for example, absorption may be too rapid and accidents must be guarded against. It will be remembered that Snirnoff reported instances of death due to a double dose of calomel being injected by mistake.

CHARLES W. ALLEN.

Book Reviews.

Wood's Medical and Surgical Monographs. Vol. X., Nos. 1, 2, and 3. Wm. Wood & Co., 56 Lafayette Place, New York.

The April, May, and June numbers of this excellent periodical publication are before us and an examination of their contents shows no falling off in their variety and value.

The April number contains monographs on the Treatment of Syphilis of the Nervous System, by Julius Althaus, M.D., Lond.; Railway Injuries; with Special Reference to those of the Back and Nervous System in their Medico-legal and Clinical Aspects, by Herbert W. Page, M.D., Eng.; Causes and Prevention of Phthisis, by Arthur Ransome, M.D.

May number. Differentiation in Rheumatic Diseases (so-called), by Hugh Lane, L.R.C.P.; Mental Affections of Childhood and Youth, and other papers, by J. Langdon Down, M.D.; Cure of the Morphia Habit, by Oscar Jennings, M.D.; Notes on the Examination of the Sputum, Vomit, Fæces, and Urine, by Sidney Coupland, M.D.

June number. Influenza associated with Nervous and Mental Diseases, by Dr. Van Deventer; Technic of Ling's System of Manual Treatment as Applicable to Surgery and Medicine, by Arvid Kellgren, M.D.; Antipyresis, by Prof. Dr. Arnaldo Cantani; Some Urinary Disorders connected with the Bladder, Prostate, and Urethra, by Reginald Harrison, F.R.C.S.

Traité Descriptif des Maladies de la Peau. Symptomatologie et Anatomie Pathologique, par MM. Henri Leloir, Prof. à la Faculté de Médicine de Lille, et Emile Vidal, Médecin Honoraire de l'Hôpital Saint Louis, etc. 3me Livraison. Paris: G. Masson, Editeur. Libraire de l'Academie de Médecine, 1891.

The text of the third number of this admirable treatise is devoted to a study of various forms of dermatitis, with dermatobia noxialis, dermatolysis, dermatoneuroses, recurring herpetiform dermatosis, dyschromia, ecthyma, eczema.

The plates are six in number and embrace twenty-seven figures, admirably drawn and colored, representing the histological lesions of polymorphous erythema, of various forms of folliculitis and perifolliculitis, and the pathological alterations peculiar to favus, Norwegian itch, etc.

We congratulate both the editors and publishers of this work upon the high standard of literary and artistic excellence thus far maintained.

Annual Report of the Supervising Surgeon-General of the Marine Hospital Service of the United States for the Fiscal Year 1890. Washington: Government Printing Office, 1890.

This report, embracing nearly 400 pages of closely printed matter, contains an immense amount of interesting material relating to the public health, quarantine regulations, hospitals, reports of hospital cases, and surgical operations, statistical tables, and other information connected with the operations of the United States Marine Hospital service for 1890.

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Original Communications.

TWO CASES OF DERMATITIS HERPETIFORMIS DEVELOPING AFTER SEVERE MENTAL EMOTION AND SHOCK.

By DR. GEORGE T. ELLIOT,

Attendant Dermatologist to Demilt Dispensary and the New York Infant Asylum, Assistant Attendant Physician to the New York Skin and Cancer Hospital, etc.

CASE I.—Female, age 55, the mother of several children, consulted me October 19th, 1885. She stated that her general health had been good up to within a few years, when she had become nervous and irritable, despondent and melancholic, in consequence of business troubles of a distressing nature. Eight years previously, she had been severely poisoned by rhus toxicodendron, but recovered completely in a few weeks. In 1883, she had received a severe nervous shock from a death in her family, and there had ensued, almost immediately after, a universal eruption consisting of "little blisters," which was accompanied by most severe itching and a swelling of her face, hands, and feet. The attack was diagnosticated by her attending physician as eczema, but proving very rebellious to treatment she went to Europe and the symptoms disappeared only after she had passed a winter in the south of France. Returning to this country in 1884, she remained well up to June, 1885, when an eruption, entirely similar to the one of '83, appeared over the entire body, coming on after a nervous shock produced by business reverses. The cutaneous and other symptoms accompanying this attack subsided in their acuteness at the end of about six weeks, but ever since there had been recurring limited outbreaks, of which the lesions present at the time of consultation were examples. These were situated on the dorsal aspects of the fingers, on the backs of the hands, the right instep, and in the popliteal spaces. On the two former, they consisted of discrete, round, reddened, infiltrated patches of various sizes, upon the surface of which there were vesicles, small crusts and points, from which a serous exudation occurred. The

newer patches were seen to be thickly studded over with tense and rounded vesicles the size of a pinhead, which did not rupture easily. In the popliteal spaces, the appearances were those usually attributed to a papulo-vesicular eczema. On the instep there was a more or less circular patch, the size of a silver dollar, from which much serous oozing occurred, and there were also several smaller crusting areas. The itching was said to be most intense and paroxysmal in character. With the exception of these symptoms, the patient's general health was very good. She felt well physically, became now only occasionally nervous and slightly hysterical, her appetite was fair, and her bowels were regular. At times she suffered from indigestion. She was subject to palmar hyperidrosis and once in a while to rheumatic pains in the knees with stiffness and weakness. The clinical appearance of the patches at this time presented to such a degree the characteristics of an eczema that the provisional diagnosis of eczema circumscriptum was made. Up to November 13th not much change had taken place. She complained several times of shooting neuralgic pains in the arms, hands and legs, and of a burning sensation in the back, and it was noticed that these pains were followed by an increase in the number of the lesions. A period of alternating relapses and improvement ensued, the patient becoming, however, depressed, despondent, and nervous from business worries and cares. On December 16th she came with an acute and universal eruption consisting of erythematous, urticarial-like patches, on some of which a number of small vesicles were grouped, and also of vesicles and papules occurring discretely between the others. The appearance of this outbreak had been preceded by excessive nervous irritability and excitement, and was attended by the most intense burning sensation and pruritus. Without any special treatment the lesions disappeared at the end of a week, only the original patches on the hands and instep remaining. January 13th, 1886, she again appeared with an acute eruption, which had come out the previous day. It was limited, however, to the face and the ears, both of which were swollen, the eyes being partly closed by œdematous infiltration of the orbits. There were slightly elevated irregularly outlined erythematous patches of all sizes occupying the cheeks and forehead, and upon some of these a number of small, grouped vesicles could be seen; on the ears there were many similar lesions, discrete and also aggregated together. Itching was not very severe, but a sensation of burning pain was complained of. The attack subsided in a couple of weeks, but it was followed by a general pruritus and frequent epistaxis, which continued until March 3d, when there was a new outbreak of vesicles upon the hands and fingers. During the interval, the patient had not once been entirely free from lesions, there having been a continual outcropping and involution of patches and discrete vesicles upon the hands and the wrists. From March 3d, the same course was followed by the disease, but its intensity became less. The patch on the ankle persisted, however, and showed no tendency to heal. In August, she went to the country and was not seen for a number of months, but reported from time to time that there

were only occasional outbreaks on the hands and the ankle. Feb. 9th, 1887, I was called to her house, and learned that about two weeks previously she had received a very severe nervous shock from the death of a daughter and she had been very irritable and markedly excitable ever since. The day before I saw her, there had appeared on the lower third of the left leg a large, irregularly outlined patch of redness, which, had, however, already become thickly studded with tense, round, closely aggregated vesicles as large as a pinhead, many of which had become confluent, presenting then a bullous appearance; others had ruptured, and the exposed surface was the seat of a copious exudation. Most intense burning pain was complained of, but no itching. The patient was excessively irritable and nervous, rather weak and prostrated.

I saw her again on the 11th. The nervous symptoms had attained a high pitch. She was exceedingly restless and hysterical, had suffered from complete insomnia and anorexia. She was constipated, tongue furred, breath offensive. Her temperature was 102° F., pulse 120. She complained of general and agonizing pruritus, associated with severe shooting neuralgic pains through the arms to the tips of the fingers, and through the thighs and legs to the toes. The eruption had appeared on the backs of the hands, on the face and scalp. On the former, there were round, erythematous, elevated patches the size of a penny, bearing five to six or more tense rounded vesicles grouped together and as large as a small pea. Discrete vesicles of the same size and small groups of papules were also distributed here and there. The face was swollen and misshapen, and over it were lesions similar in every way to those just described. The same features were present upon the scalp. The lesions were unconnected with the hair follicles. The evolution of this outbreak was said by the patient and her family to be so far in strict accordance with the previous attacks in '83 and '85, so that it may be concluded that they were also of the same nature as the present one. This was easily recognized as being an acute outbreak of the dermatitis herpetiformis of Dr. Duhring, a diagnosis which had, moreover, been made more than a year previously, at the time of the repeated relapses mentioned as occurring in 1885 and 1886. The evolution of this attack was steady and rapid, and the general condition and cutaneous symptoms became so aggravated and distressing that I recommended the patient to enter the Skin and Cancer Hospital. She did so on February 16th, going into Dr. Bulkley's service. He corroborated the diagnosis and kindly left the patient in my care. On admission to the hospital she was thoroughly examined. The eruption was situated upon the backs of the hands and around the finger nails, the insteps of the feet, the dorsal aspect of the toes, especially about the base of the nails. The lateral surfaces of both fingers and toes were markedly affected, as were also the palms and the soles. The extensor surfaces of the upper and lower extremities were severely, the flexors only slightly implicated; the bends of the elbows and the popliteal spaces were free. The eruption was further distributed over the chest, abdomen, shoulders, and back as far down as the lower borders of the scapulæ, but not very

markedly so; the lower half of the back was free. The cheeks, eyelids, and lips were œdematous, the entire face misshapen and distorted, and both it and the scalp severely affected. On all of these surfaces, except on the hands and feet, which require special description, there were innumerable papules, papulo-vesicles, and especially vesicles, single or arranged in groups of three or many more. In fact, some groups were as large as a silver dollar or much larger. The patch on the left leg, where the eruption had begun, was now four inches by two, and oval in shape.

The grouped lesions were seated upon a slighly elevated, infiltrated, bright red base. The discrete vesicles seemed, however, to arise from normal skin, and in many places the appearance was that of a surface covered with drops of dew. In size, the single and discrete papules and vesicles approached that of a small pea; the grouped ones varied from that of a grain of sand to a pinhead. In shape, the papules were rounded and dense, but many resembled those of eczema papulosum; the vesicles were for the most part tense and round, but also irregularly shaped and flat, especially some hours after their development. There were also many small crusts and scratch marks. On the fingers and on the palms, the lesions were small bullæ one-fourth inch in diameter, and also groups of vesicles. On the palms these latter had become confluent and formed large, irregularly shaped patches. On the soles, the bullæ varied in size from that of a large pea to a pigeon's egg and larger, the largest being situated at the root of the toes. On both feet a number of the large bullæ were arranged almost linearly along the course of the internal plantar nerve from the heel to the last phalanx of the great toe, which was entirely occupied by one bulla. Smaller lesions were similarly arranged along the course of the ext. plantar nerves. These bullæ were tense and rounded, and ruptured only with difficulty. A few were encircled by a narrow halo of redness. On the dorsum of the toes and around the nails there were large, thin-walled bullæ. The contents of all of these, as well as of the vesicles, were at first colorless or faintly yellow, later becoming slightly cloudy or in the larger ones turbid. The fluid was neutral in reaction. The subjective sensations existing before the patient entered the hospital continued as severe as ever. The intense itching, burning, and shooting pains in the extremities were pitifully complained of. The patient was exceedingly hysterical, became, moreover, easily excited without provocation and would burst suddenly into tears. Total insomnia continued. Her temperature was 100° F., pulse 120. Toward the evening of the first day the symptoms referable to the nervous system became intensified in degree; the exacerbation continued for several hours, and after their subsidence the patient was left absolutely exhausted. This feature in the disease had occurred regularly every day from the very beginning of the attack, and, as will be seen, manifested itself frequently while she was under my care.

February 17th. The patient had had a fairly good night. Many new groups of vesicles had appeared on the arms, thighs, and but-

tocks, some of the bullæ on the palms and soles had become larger, others had ruptured and collapsed, and a serous fluid escaped through the opening made in their walls. The œdema of the eyelids had subsided. The itching was only moderate; she felt quite comfortable; A.M. temperature 99°, pulse 90. Toward evening there was another hysterical attack, similar to the one the day before, after which she felt easier; P.M. temperature 100°. The urine had been examined, but no evidences of renal disease were found.

February 18th. The past night the patient was more or less restless, slept only little. No new lesions had appeared, but many of the groups, by confluence of the component vesicles, formed irregularly shaped, bullous-like patches, and there were numerous crusts over the body. The fauces were brilliant red and dry, a few purpuric spots on the tongue, but no lesions could be detected (these symptoms were undoubtedly due to atropia, of which she was getting $\frac{1}{80}$ gr. ter in die). The temperature was normal, but she was more or less hysterical and nervous. P.M. The large bullæ on the soles were incised, their thick walls cut away, and the denuded surface dressed antiseptically. At 3:30 she had a slight rigor. At 5 P.M. the temperature was 104°; the pulse 102, full and strong. She was exceedingly nervous, the entire skin markedly hyperæsthetic; she complained of excruciating shooting pains through the arms, hands, legs, and plantar surfaces of feet, of such severity that she would jump up in bed and cry out. Under the influence of antipyrine the temperature fell to 100⅗, the pulse to 85; by 7 P.M. the patient felt better, was less nervous, the pains had greatly diminished both in intensity and in frequency, and, the antipyrine being repeated, the temperature became normal; she felt comfortable, but exhausted.

February 19th. The night had been quiet. The temperature remained normal all day. The shooting pains and the hyperæsthetic condition of the skin had disappeared and remained away. Many of the patches of vesicles had dried up, the lesions forming small crusts, on the older ones there was slight scaling. The patient was given Fowler's solution gtt. v. ter in die.

February 20th. The temperature, A.M., 95⅘°, pulse 92. Insomnia the night before, she was nervous and restless, there was a renewal of the neuralgic pains through the extremities and of the excessive itching. She felt cold and chilly. The head was heavy, hot, and ached severely. Anorexia. The bowels had moved freely, and abundant urine was passed. No new lesions, but the old ones were drying into small yellowish crusts. At 4:30 P.M. the nervous symptoms had become excessively distressing, temperature had risen to 102°. Under antipyrine grs. xv. the temperature fell to 100°, there was only slight pain in the right elbow and knee, burning and itching. The neuralgic pains were not followed this time by an outbreak of lesions of any severity, only one bulla as large as a buckshot appearing on the palm of the left hand.

The 21st was a good day, but during the night there had been complete insomnia, and there was a return of the burning, itching, and

shooting pains on the morning of the 22d. The pains were felt especially at the knees and over greater trochanters, but also through the entire distribution of the sciatics. She said that they seemed to begin in the heels—the left one being the severest affected—and shoot upward. They were not very marked in the arms. About the middle of the day a new outbreak of vesicles and papules, arranged in small groups, was observed on the hands and trunk, and in the evening a bulla as large as a hazelnut appeared on the sole of the left foot just external to the median line, and arranged around it were several small vesicles. The temperature had been normal all day. Toward evening the pain had subsided considerably, as had also the severe headache, which had been present since morning.

February 23d was characterized by intense burning and itching alone; the 24th and the 25th by the neuralgic pains in addition. Only a few discrete vesicular lesions had appeared on the left palm and a small bulla on the right sole. General improvement had taken place on the body, arms, legs and face, there being only crusts and red, scaly patches, where the lesions had been. On the 26th, however, the patient had had a bad night, and in the morning was nervous, restless, and despondent, had pains in finger joints and severe headache. One new bulla on left palm. The temperature had been normal since the 21st, and remained so as long as she was in the hospital. From the 26th to March 1st, the eruption subsided steadily, and great improvement was noted; the cutaneous symptoms had disappeared in great part, there had been no return of the neurotic disturbances. On that day, however, she complained of a prickling sensation and a twitching of the muscles of the left half of her face. The symptoms subsided at the end of two days, and nothing special occurred until March 5th, when the patient became nervous and restless, the shooting pains returned and were present to a severe degree, and an intense left hemicrania developed, accompanied by slight conjunctivitis of the same eye. No lesions appeared, however, and the following two days —the 6th and the 7th—were passed quite comfortably, but on the 8th and the 9th the same neurotic symptoms as before were again manifested. There was only slight left hemicrania on the 10th, but on the 11th an eruption of small grouped papules and vesicles occurred on the dorsum of the hands, though the patient felt quite comfortable. No special symptoms ensued and the woman left the hospital on the 15th of March. Her condition was quite good, though she had lost considerable flesh, was weak, but her nervous irritability had much diminished and the pruritus was only occasionally troublesome. The cutaneous surface was for the most part clear of lesions; here and there were some small crusts, patches of redness which were slightly scaly, a desquamating condition of the forehead, and a few small vesicles on the backs of the hands, arranged in groups and resembling the patches seen at the time of the first visit. There was no pigmentation. The patient had up to within a few days continued taking Fowler's solution gtt. vij. t. i. d., but it had been stopped owing to diarrhœa. Her treatment had been almost entirely symptomatic, with

the exception of the arsenic and, during the first few days, atropia. Externally, dry starch had given considerable relief, but the application of salicylic acid in ungt. diachyli (gr. x.: ℥ i.) had been the most grateful.

On leaving the hospital, the woman returned to her home, the one where she had lived with her daughter. Her loss was again vividly recalled to her mind, her grief returned as acutely as before, nervous excitement and a hysterical condition reappeared. In a few days, the neuralgic pains in the extremities and excessive left hemicrania redeveloped; with these, profuse sweating was associated, and finally, on the 22d, grouped vesicles and papules, accompanied by the former intense burning and itching, began to crop out on the backs of the hands and on the thighs. The attack subsided by the beginning of April, but the patient, being subjected to business worries, the same train of symptoms manifested themselves again, the lesions being this time distributed quite generally over the trunk and the extremities and appearing in groups of three or more on an erythematous base. There were also small bullæ, the size of a large pea, partly or entirely surrounded by small vesicles the size of a pinhead. Many of the vesicles were irregular and angular in shape, but for the most part round and tense. She also suffered from thirst, there was a slight cystitis, but no pyrexia. By April 25th considerable improvement had occurred, but there were still some pains in the joints, the left side of back, chest, and head, and also lesions on the dorsum of the hands, the right ankle, and the abdomen, and two bullæ on the sole of the left foot. In the two former situations the appearances were the same as have been described, but on the abdomen they were of an entirely distinct and new type, consisting here of round patches as large as a fifty-cent piece or a nickel, the centres of which were red and infiltrated, while the peripheries were bounded by a row of small tense and rounded vesicles, or by small crusts caused by the drying up of these. The itching was excessively severe.

Up to July 10th there were alternating periods of improvement and relapses, the latter diminishing in intensity, but always manifesting themselves after worry or excitement or anything disturbing her equilibrium. On the above date, the patient was entirely free from the cutaneous disease, but only for a short time, for she returned on the 20th of July suffering from a new outbreak on the backs of the hands and on the extremities, one which had developed immediately after a period of nervous excitement. I recommended her to go to the country and seek rest from all worry, and a change of climate and scene. She went to Nova Scotia, and while there she remained perfectly well, no outbreaks occurring, nor any of the distressing subjective sensations developing. She returned to New York on September 1st, and was seen by me on the 9th. Her general condition had much improved, she was stouter, stronger, and looked in every way better. Still, since her return she had been subjected to business troubles of a peculiar nature. On the 5th she had had shooting neuralgic pains through the chest, and on the 6th had noticed the appearance of lesions

in the epigastric region. She stated that at first they consisted of a number of small vesicles grouped together on one base, but when I saw her there were a few patches covered with small crusts and a dozen or more erythematous, infiltrated, more or less round spots about the size of a ten-cent piece, the peripheries of which were bounded by a chaplet of small vesicles. There was also on the right ankle a group of vesicles the size of a silver dollar, which had become more or less confluent. The lesions were most intensely pruritic. It was also noticed that the nails of the fingers and of the toes had undergone a process of shedding and replacement by new ones, which had not yet fully grown. This attack subsided rapidly, and comparative quiescence followed, broken, however, by slight relapses. Of these there were quite a number up to June, 1888, and each was invariably brought about by a nervous attack or mental trouble or after a period of depression. Since that date she has been under my observation, but, her family and business life having been of a character which excluded nervous shocks, irritation, or disturbances of any kind, the patient remained well up to February, 1890, when she came with a fresh outbreak on the backs of the hands and fingers and on feet. The appearance of the lesions was preceded by neuralgic pains in the extremities, which developed after a severe fit of anger. The lesions were the same as when she was first seen, and subsided rapidly under the ointment. Since that time the cutaneous symptoms did not manifest themselves until December, 1890, but the patient suffered from a severe and rebellious diarrhœa for a period of two months. This had begun immediately after the subsidence of the last outbreak of lesions on the hands.

On December 16th, 1890, pain developed in her knees, elbows, and back, neuralgic and shooting in character, followed by absolute paresis of her right side. This lasted for several hours, and then gradually passed away. It was followed by a severe hysterical attack and great weakness, and an eruption on hands and forearms of groups of vesicular lesions and on soles of large bullæ. Intense burning and itching ushered in the eruption. It subsided, however, at the end of a few weeks, though the patient still remained weak. Since that date there has been no return of cutaneous symptoms.

CASE II.—Male, age 53, perfectly well as far as his general health was concerned, but continually subjected to worries and anxieties, received in the fall of 1888 a severe mental shock, from the death of an old friend. A few days later a universal pruritus developed, which was most intense on the extremities, and at the end of two or three days erythematous patches, papules, and vesicles began to appear. The latter were discrete to a certain extent, but mostly arranged in groups, and they were distributed over the extensor surfaces of the arms and legs. The pruritus, present all the time, became at times paroxysmal in character, and so severe as to produce insomnia and a condition of hysteria. In its course, crop after crop of lesions developed, at one time erythematous, at another vesicular or papular, and all treatment appeared useless. At the end of a few months the patient

took a trip abroad, and the eruption disappeared quickly and remained away for a number of months. On his return slight outbreaks occurred occasionally, especially when he became much fatigued or worried, and their appearance was always preceded and accompanied by severe pruritus. At times these relapses clinically resembled herpes most strikingly, consisting of irregular, flattened vesicles grouped upon an elevated reddened base and leaving pigmentation after their disappearance. In the fall of 1889 the patient again received a mental shock, but slight in degree. It was immediately followed by pruritus and intense burning over the legs and an outbreak of erythematous patches of all sizes and configuration. Subsidence ensued in the course of a few weeks, and since then he has been free from the disease.

The two cases the histories of which have been recorded in this paper appear to me to represent exquisite examples of the dermatitis herpetiformis of Dr. Duhring. In their course, clinical symptomatology, objective and subjective manifestations, they presented in a most decided manner the characteristics attached to the disease by him, and later by Brocq in his superb critical analysis; and they possessed, moreover, a stamp of individuality which entitled them to be considered as examples of some distinct morbid process, and not as atypical cases of some cutaneous disease or other, such as erythema, or eczema, or pemphigus. The clinical histories and manifestations of these two cases are not, however, of as great interest and importance as is the fact that in each one a precise etiological factor—a severe mental and moral shock and emotion—immediately preceded the appearance of the disease, and could be accused as the determining and active cause of its development. In this particular, however, these two examples of dermatitis herpetiformis do not stand alone, for in Brocq's analysis we find that similar or identical moral or mental emotions or shocks preceded in several cases the development of the cutaneous disease, whether these were of an acute or chronic type. He cites one of Devergie, one of Crocker, and one of Vidal which followed upon a severe fit of anger; one caused by fright (Gibert); another is reported by Duhring, and still another is recorded by Brocq himself, due to the same influence. An unspecified violent emotion is mentioned by Cazenave as the determining cause of a cutaneous disease, considered as an example of dermatitis herpetiformis by Brocq, and more lately Tenneson reported a case developing after the reception of a violent mental shock—the death of a son. If my two cases are added to these, we thus find that there are ten instances of this dermatosis, in each of which the existing etiological factor preceding the development of the disease was some severe mental emotion or shock, and owing the intimate relation seemingly existing between the eruption

and the reception of the shock, as evidenced by the immediate development of the former after the latter, it would certainly appear as though the origin of the cutaneous disease could be attributed to the mental emotion or shock received.

Similar causes have frequently been observed to determine functional and even organic diseases of the nervous system. Charcot mentions paralysis agitans as well as other severe and grave neuroses; Leloir, epilepsy, while neurasthenia and insanity originating from such etiological factors are too well known to need more than casual mention. If such severe affections as those mentioned can, therefore, arise from mental emotions and shocks, we are unquestionably justified in supposing that in certain individuals the influence of such factors upon the nervous system could manifest itself in the production of neuroses of other kinds, affecting other portions of the body, and of lesser, or at any rate of not so grave, severity, and among those that arose might be dermato-neuroses. In fact, many instances of other cutaneous diseases than dermatitis herpetiformis have been recorded by distinguished observers as developing immediately or shortly after the occurrence of severe emotions and shocks. Leloir, who has recently studied the subject carefully, states that he has seen erythema, urticaria, herpes, bullous dermatoses, pemphigus and pemphigoid eruptions, etc., arise secondarily either to moral emotions of long standing or to such as were sudden, brusque, violent, and of short duration. He believes, however, that predisposition plays an important rôle, the conditions necessary being the nervous and impressionable state of the subject or a predisposition to the dermatosis; and he adds that, whereas in a healthy person the cutaneous neurosis produced by a mental shock would only be transitory, yet in one predisposed the process would be more accentuated, intense, and permanent. Now, if the development of various dermatoses has been so frequently observed after mental emotions and shocks that Leloir was able to formulate conclusions in regard to them, and to regard the facts recorded in the light of cause and effect, it would appear to be perfectly proper for us to consider instances of dermatitis herpetiformis arising under conditions similar to those other diseases as standing in the same relationship to the etiological factors which immediately preceded their development, as do those other forms of disease mentioned; or, in other words, we are consequently in a position to conclude that the immediate and determining cause of the dermatosis in these cases of dermatitis herpetiformis was the mental shock and emotion received by the patient. Under these circumstances, therefore, we will be obliged to regard them as examples of a dermato-neurosis, inasmuch as it is only through the nervous

system that such causes can or do exert their pathological influence and bring a cutaneous disease into existence, and it is consequently in this category—dermato-neuroses—that I would place the two cases reported here by me, as well as others developing from similar etiological factors.[1]

In the study of the instances of the disease which I have just described, it was most clearly evident from their entire pathological course that their existence was intimately connected with a disturbance of some kind in the nervous system, and essentially dependent upon it. In both predisposition existed, in so far that in the one (Case I.) the woman was worn out with anxiety, want of rest, etc., from nursing the member of her family who died just before the first attack of the disease, she was hysterical and nervous; in the other (Case II.) he had been subjected for years to severe responsibilities, cares, and worries, which had impaired his general health. In Case I. complete recovery took place after a certain length of time, and she remained well, until, experiencing another mental emotion and shock—from business reverses—a relapse occurred. From this time on, every relapse, slight or great, every recrudescence of the cutaneous symptoms, subjective or objective, could be traced to some such slight or severe mental emotion or impression, or increased worry, or care, or anxiety and furthermore the grade of the relapse, whether transient or grave, varied according to the grade of the emotion, shock, or other disturbance received. It was also constantly seen how objective manifestations constantly followed immediately upon neuralgic pains, or a hemicrania or some other evidence of disturbed sensory innervation. Still more conclusive, perhaps, of the neurotic character of the disease was the observation that diminution in the severity of the subjective and objective manifestations occurred in proportion as the patient's *morale* improved, and the final cessation of the pathological symptoms and entire quiescence of the disease were only obtained when the changed circumstances of the patient's life protected her against the occurrence of mental emotions or shocks and precluded the experience of annoyances, worries, or cares.

[1] I have referred here only to those cases of dermatitis herpetiformis which developed secondarily to sudden, violent, and brusque emotions and shocks. Still, I believe that *all* cases of the disease represent dermato-neuroses of one grade or another, and that in all a disturbance of the nervous system is the important and essential etiological factor, although that disturbance may be brought about by manifold causes, occurrences, or conditions exerting their influence and producing their effects upon the nervous system in some one way or another. In reporting some further cases of the disease, which have been under my care, I hope to demonstrate possibly more clearly the confession of faith just made by me, and therefore will not enter upon its discussion here.

In Case II. very much the same course was observed, but it was a much less severe example of the disease. Relapses, however, were always preceded by conditions, occurrences, or emotions operating upon the nervous system, and periods of quiescence occurred only when these were absent. Entire recovery has taken place, owing to the patient's care in avoiding everything which could in any way lower the tone of his general health. From the evidence furnished by their etiology also, and especially by their pathological history, these two cases of dermatitis herpetiformis may, therefore, in my opinion, be directly connected with some pathological condition or disturbance brought about in the nervous system by the severe mental emotion which preceded immediately the development of the objective and subjective symptoms. When, however, the questions are asked, Where in the nervous system is the lesion situated? what centre or centres are affected? and what is the nature of that lesion? there is no answer to be given beyond a speculative one. Clinically, we may presume that it is the central nervous system which is the seat of the disturbance, but yet we have no indisputable proof of that fact. Upon the same grounds we may theorize that the lesion causing the cutaneous disease may be a functional one or one of nutrition, some nutritive change, or in some instances even organic, but yet we are even then not any further advanced than we were before. As Brocq says, however, whatever the lesion may be, it must in the majority of cases be a transitory one, in view of the frequent cures observed, or, at any rate, entire temporary recoveries. Whether we shall ever arrive any nearer to a conclusion, or have any positive knowledge, in regard to the changes causing dermatitis herpetiformis, are questions certainly far more easily asked than answered.

7 WEST 31ST STREET.

PEMPHIGUS FOLIACEUS MALIGNUS.

BY W. L. MUNRO, M.D.,
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G. T. SWARTS, M.D.,
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THE following is a typical case of a disease sufficiently rare in any part of the world, but particularly so in this country, where we should hardly expect to meet with it outside of the very class to which this patient belonged, viz., recent immigrants, who, belonging to the poorer and uneducated class abroad, continue to live in much the same manner here as there.

Mrs. R., 37 years old, Jewish, native of Galicia, came to this coun-

try about three years ago. Family history negative; no specific history obtainable and no evidences of specific trouble to be observed in other members of the family.

I first saw Mrs. R., May 1st, when she assisted me while calling professionally upon one of her neighbors. At that time she appeared fairly well nourished and in good health. Noting her appearance casually, the only particular attracting my attention was the deep-red, congested appearance of the skin of her face. This, however, is not uncommon among those of her race and mode of life.

May 8th. Again met patient at same place. She called my attention to the condition of her lips, tongue, and mouth. Both lips presented a raw surface throughout the width and almost the whole extent of the vermilion. The tongue and interior of cheeks were closely studded with superficial, circular excoriations, shallow, with inflamed, slightly grayish bases. Edges of these excoriations and rest of tongue presented a dirty white coat. The ulcerations upon the lips and in the mouth were, on the average, about the size of a split pea in circumference. One or two small unbroken but flaccid vesicles appeared upon the columna nasi. Her appearance at that time reminded one strongly, in its external characteristics, of the aggravated cases of herpes labialis frequently seen accompanying acute lobar pneumonia.

As she asked no advice, I volunteered none. May 13th, five days later and about the seventh day of the disease, I was summoned to see the patient, who had been until then under the care of the "lodge-doctor."

The appearance was now markedly different from that before observed. Tongue and whole interior of mouth raw, inflamed, and bathed in slightly bloody muco-pus. Lips and edge of nose covered with brownish, bloody crusts. Numerous small vesicles extending in a circle about the waist at the level of umbilicus. These were for the most part small and set closely together. Occasional vesicles attained the size of a pea, or even of the end of a lead-pencil. Some of these, especially upon the back, had been broken, as if by moving about in bed, and presented a raw, oozing base. A very few small scattered blebs were seen upon the back between scapulæ, and on the anterior aspect of the chest.

Upon each arm, but without regularity of arrangement, numerous vesicles appeared, discrete in some parts, at others resembling herpetic patches in their grouping. Both here and about the abdomen the majority of the vesicles presented a wrinkled, flaccid appearance.

Great difficulty in swallowing, owing to the raw condition of the mouth, almost entire loss of appetite, great prostration and weakness, inability to obtain sleep. For two to three days stomach had been

very intolerant, there having been frequent attacks of vomiting. Matters vomited, besides ingesta, consisted almost wholly of bloody mucus. Bowels somewhat constipated.

There had been considerable sharp, burning pain in the region of the vesicles about the abdomen and on the arms, and, underlying this, a dull aching. Patient was given milk and lime-water, in exceedingly small amounts, and frequently; sulphate of quinine gr. ij. every four hours; brandy, one dessertspoonful every two hours; myrrh-wash as a gargle for the mouth. For the unbroken vesicles I used flexible collodion, with ten grains of morphine to the ounce, painted on the vesicles as soon as they appeared, and before they were broken; for the broken and painful vesicles, zinc ointment with the same proportion of morphine.

May 14th. Patient slept probably three hours during night; vomited frequently, vomitus being of the same character as before, but has retained some food and most of the stimulant. Pain, as a whole, is less severe, but she now complains of pains through the chest on either side, with some cough and expectoration.

Vesicles and small blebs, similar to those previously described, but more inclined to be discrete, are now seen running down the outer and anterior aspect of the thigh and leg, as well as about the nates. A few of these are already broken and ooze.

The older ruptured vesicles ooze freely. Those which were painted with anodyne collodion remain intact, though occasionally, especially upon the back, they have ruptured just sufficiently to allow the contents to escape.

No well-marked plan of distribution upon the legs, but eruption has extended down from the buttocks to the ankles.

Bowels had moved since previous visit. Continued treatment. Ordered also morph. sulph. gr. $\frac{1}{8}$ to be given at night if required.

May 15th. General condition but little changed. Stomach is more tolerant, vomits little, nourishment and stimulant taken fairly well. Some new vesicles upon the abdomen and back. Those now appearing average larger than those first observed, and show a tendency to collapse and exfoliate quickly. Vesicles and blebs upon legs and buttocks are more numerous. In cleft of nates and about the anus, parts naturally moist, exfoliation has occurred over some spots in spite of the use of the anodyne collodion. Vulva involved for the first time, labia majora and minora being completely covered with small and closely packed vesicles, from some of which a serous discharge is oozing. The vaginal mucous membrane was becoming involved.

Late in afternoon of same day the epidermis covering the vesicles

upon the vulva already had a macerated look, as if likely to exfoliate. New blebs appearing on abdomen.

Up to this point patient's strength had been fairly well maintained, in view of the serious constitutional disturbance.

After this visit I lost sight of her for eight weeks, during which time she was under the care of the "lodge-doctor" who had first attended her.

July 10th. Mrs. R. was admitted to the Dermatological Service of the Rhode Island Hospital, under the care of Dr. Swarts, by whom the following notes were supplied:

"On admission presented the following lesions: Scalp, chest, and abdomen were covered with thick masses of crusts of half an inch in thickness. The crusts were dry, laminated, tough, and firmly adherent; in color were dark yellowish-brown. Upon the arms, hands, and feet were numerous vesicles, blebs, and bullæ from size of a split pea to that of a silver dollar.

"The axillæ, groins, hips, neck, beneath the eyes, and the entire back were covered with macerated epidermis, here and there torn off in shreds, leaving a raw, intensely inflamed, and bleeding surface, the condition being similar to that resulting from a superficial scald. Most of this raw surface was bathed in serum, which rapidly became decomposed into pus. The odor from this discharge was so offensive as to necessitate her removal to a private room.

"The general conditions suggested exposure to insanitary conditions, lack of food, and uncleanliness, but inquiry partly disproved this. The only etiological factor which I was able to obtain was depression of spirits from loss of children. At time of entrance she was constantly begging for medication to hasten death. The patient presented a most pitiful condition, being extremely emaciated, and, with the accumulation of crusts, pigmentation of skin, and loss of hair in removing crusts, suggested mummification. Both feet were œdematous, temperature 100, and urine negative. She complained of pain over the whole body. Greenish watery discharge from the bowels every half-hour. The tongue and mouth were completely raw from exfoliation, and it was evident that the disease had invaded the whole alimentary canal. The patient was at once put upon the most nutritious and stimulating diet possible, and the diarrhœa partially checked with Squibb's mixture. The stomach gaining tone from the presence of food, the diet was rapidly increased. Ten days after admission she was receiving, in addition to the regular house diet, four ounces of milk and two drachms of bovinine every four hours, brandy or wine every four hours, and five eggs per diem; for medication syrup of iodide of iron, gtt. xv. t. i. d., bismuth and lactopeptine for the alimentary disturb-

ances, and phenacetin or morphia occasionally for pain. Fowler's solution, two gtt. t. i. d., was administerd, as possibly having a specific action, but the main reliance was upon the diet.

"The patient in about two weeks began to respond, gaining in flesh, though not so much in strength. The blebs and bullæ have continued to appear, but have been confined to the hands, wrists, and feet. At times of small size, they appear more commonly from the size of a quarter to that of a dollar, and occasionally much larger. The vesicles form rapidly, and break almost spontaneously, before being completely filled, leaving the rete and corium exposed. This whole process is completed within a few hours. These surfaces, as also the whole region of the back, are being treated by cloths wrung out in bichloride of mercury solution, 1 to 4,000, which has had the double effect of preventing suppuration and stimulating the unhealthy raw surfaces. These are allowed to remain from a half-hour to two hours, according to the area, after which oxide of zinc ointment is applied. This local treatment has been highly satisfactory, the surface of the back having already healed by granulation, except on a few isolated spots, without the formation of crusts.

"Occasional small crops of blebs or vesicles still appear upon the hands, feet, and wrists, but the individual lesions average smaller. Bowels are under control. Mouth and tongue are healing. Lips, face, back, and most of trunk have presented no new lesions for some time.

"The patient's general condition, though still serious enough, is evidently improving. Her ability to heal over the very extensive raw surface upon the back encourages us to offer a favorable prognosis, provided she remains where she can be properly cared for. The disease has now lasted fourteen weeks."

The diagnosis of pemphigus foliaceus was made from the character, size, and general dissemination of lesions, the rapidity of their evolution, and the constant though irregular succession of crops. The gravity of the symptoms as a whole stamped the case as malignant. At the time of entering hospital a fatal termination appeared to be close at hand.

Resembling herpes at the very outset, while the vesicles were still small, it is now easily distinguished by the size and location of the lesions, their mode of evolution, and the course of the disease.

From herpes iris it is distinguished by the absence of coloration or orderly arrangement. From the bullous syphiloderm it can be differentiated—negatively, by the absence of specific history; positively, from the character of the crusts, which, though heaping up into cones in some parts, notably the abdomen and axillæ, can be readily

removed, leaving a healthy base, without ulceration or secretion, and also from the recovery, which thus far seems assured, entirely without specific medication.

DERMATOLOGICAL NOTES.

By GEORGE THOMAS JACKSON, M.D.,

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THE following cases from my Randall's Island notebook, though far from being models of completeness, are offered in the hope that they will prove of some value, to the compiler of statistics at least.

CASE I.—November, 1889. *Tuberculosis verrucosa cutis.* J., aged 18 years, male, idiot. This poor boy was both an idiot and an epileptic, and so stupid that it was impossible to obtain a history of his case. The disease was first noticed five months ago, when he was transferred from the idiot pavilion to the hospital on account of some caseously degenerated glands in his right groin. The patient was taking large doses of bromides for his epilepsy, and had many acne lesions scattered over his boby.

My attention being called to the case, I found, besides the bromide acne, upon the posterior surface of the right thigh, and midway between the buttock and knee, a round, circumscribed, inflamed, dark vinous red, thickened, and raised patch. Its surface was superficially ulcerated in some places, and in others presented a verrucous appearance. By squeezing the mass a few drops of pus would well up between the papillæ. While the patient was kept in bed the ulceration would entirely heal, to begin again when he was allowed to be up and about the ward. When the ulceration was absent the patch presented the characteristic red halo, inside of which was a watery area, and inside of this a depressed cicatrical centre. There were no lupus nodules in or about the patch. I curetted the mass entirely away, dressed the wound antiseptically, and in four weeks' time, there was left only a smooth bluish cicatrix. It was noticeable that, in scraping, the warty part gave way readily under the curette, while the centre of the patch offered complete resistance to the instrument.

CASE II.—October, 1890. *Lumbo-crural zoster.* Bridget, aged thirty. This case was of interest on account of the great extent of the eruption, which involved the right buttock and the inside of the right thigh and leg to the ankle. It ran a typical course, and became well under purely expectant treatment.

CASE II.—October, 1890. *Loss of nose on account of syphilis.* Louisa, aged 13 years. All that can be learned of the history of the case is that it began six years before entering the hospital, and that it has been on the nose alone. The girl states that nothing has ever been done for her, the parents not even taking her to a dispensary. She presents a truly frightful picture, the whole middle part

of the face having been destroyed. The nose is gone, leaving the bones intact. Nearly the whole of the lower eyelids is wanting, and what remains is pulled down so that the eyes cannot be closed. The upper lip is gone, and the teeth of the upper jaw are partly out, those that are left being loose in their sockets, and turned forward and outward. A constant stream of mucus flows out of the open nostrils and down over the exposed upper alveolar process. There is also a flow of tears out of the open eyes, and more or less conjunctivitis. The diseased surface as a whole presents a scalloped border, and is of dark red color. The general health of the patient seems to be good, and there is no evidence of tubercular trouble anywhere.

The diagnosis of this case was between lupus and syphilis. Lupus was excluded by the comparatively rapid course of the disease, the absence of all lupus tubercles, the escape of the bones, the sharply circumscribed character of the patch with its scalloped border, and the entire want of any other evidence of tubercular disease. The diagnosis was further verified by the rapid amelioration of all the appearances under appropriate anti-syphilitic remedies, so that now, within seven months, we are discussing the possibility of a plastic operation for improving the appearance of the patient.

CASE IV.—December, 1890. *Dermatitis herpetiformis.* John, aged 23 years, driver. Has had the disease for fourteen years, and has been under the care of many physicians. The present outbreak is of some weeks' standing. He says that he is never entirely free of some evidence of the disease. It now involves the whole trunk and extremities, but the face is free. The patient states that the face has never been involved. The eruption is of the papulo-vesicular type, the vesicles being in well-marked groups. There is a great deal of pruritus, so that there are many excoriations. Apart from the skin, the patient seems to be in good general condition.

Following the suggestion of Dr. Duhring made at the meeting of the American Dermatological Association in September, 1890, I ordered him to rub himself with sulphur ointment in the strength of two drachms to the ounce of lard, and in seven days he showed a vast improvement, and in less than a week more, before I made my weekly visit, he had gone out in a condition that he considered as good as well. The effect of the treatment was to me a most agreeable surprise, as also to the patient.

A Group of Molluscum Cases.—Some have doubted the contagiousness of molluscum epitheliale. During this spring we have had a little epidemic of these cases in our children's pavilions. The first case that came under observation was on April 23d, 1891. One week afterward there were two cases more. In another week one more new case was found, and in the next week two more. I then went off duty. All the cases were little girls, running from three to seven years of age. While they did not sleep in the same pavilion, they all played together.

14 EAST 31ST STREET.

Selections.

Syphilitic Immunity. DR. HUDELO. (*Annales de Derm. et de Syph.*, May and June, 1891.)

The author has set himself the task of demonstrating the truth of the law of syphilitic immunity; of finding when this immunity begins, whether it ever ends, and, if so, when; and if it is transmitted to the offspring.

He believes that in considering this question we must not look too much to what takes place in vaccination, variola, etc., for analogy, as there are such great differences between these acute cyclical processes and syphilis.

The history of experimental inoculation is passed in review, and the opinion is advanced that, in all the older cases in which pustules developed soon after inoculation, it was ecthyma which was inoculated, and as a result ecthyma was obtained. It is not thought necessary, in order to explain the lesion occasionally produced by the inoculation of a syphilitic subject with syphilitic virus, to create a third variety of chancre (the chancroïde). They are for the author mixed chancres, from whose surface syphilitic virus and chancroidal virus can be taken at the same time. The first does not take effect because of the immunity of the subject, while the second produces a chancroid.

The author believes that absolute immunity for syphilitics in the course of their secondary manifestations is proven by numerous experiments, and it is also proven clinically, for there are no authentic instances of reinfection in a syphilitic showing secondary signs. Now comes the question. Does immunity persist after the truly virulent period of the disease; that is, after the secondary period? In the subsequent course of the disease there is still a certain degree of general infection of the organism, since the disease can be still transmitted to the progeny. We can affirm, the author says, that the immunity exists at this period, just as in the secondary. This is proven by the negative result in all reinoculations of syphilitic lesions in individuals with tertiary syphilitic lesions.

Clinically, this immunity in tertiary syphilis is established also. Only a few observations of reinfection under these conditions are known of. One of the latest, that of Ducrey, the author thinks, is susceptible of serious objections, for there exist tertiary ecthymas and superficial cutaneous lesions, appearing only after several years of syphilis, which might be confounded with secondary manifestations. The conclusion is drawn that every syphilitic in the course of his syphilis finds himself, from the fact of the infection which he has undergone, in a state of absolute immunity, and can neither be reinoculated nor reinfected. Nothing proves that the immunity is less real in the tertiary than in the secondary period. It lasts as long as the syphilis itself is in a state of evolution.

AT WHAT MOMENT DOES IMMUNITY BEGIN?

Does it exist from the period of incubation of the chancre? Experimentally the question is difficult to decide. Few observations have been published. Those of Gibert and Belhomme are quoted. Gibert inoculated a healthy individual, and at the end of five days made a second inoculation, and two days later a third. Two syphilitic chancres developed, but the third inoculation was negative.

In Belhomme's case a second inoculation was made the day following the first, and a third five days later. Thirty-five days after the first inoculation chancrous papules appeared at the first inoculation, and the other two remained negative. Here it would seem that the immunity was established during the incubation of the chancre from the first inoculation. Three experiments with opposite results are given, from which Mauriac concluded in 1883 that reinoculation is possible before the appearance of the chancre, and up to the twenty-second day of inoculation.

Experimentally, then, immunity is not necessarily established from the beginning of the incubation of the chancre. Is it surely so once the chancre has appeared? Is the chancre, in other words, reinoculable on the bearer? When Hunter admitted it to be so, it must be remembered that he confounded the chancre and the chancroid, and knew nothing of the mixed sore.

All results, the author thinks, which have been called positive, only prove that septic matter, not specific, has usually been inoculated, and in other rarer cases chancroidal virus taken from mixed sores has been used.

To-day it is admitted by all authors that non-reinoculability is the characteristic of the syphilitic chancre, and that from the time the chancre appears the immunity is produced in general. While certain authors (Mauriac, for example) seem to admit that this rule is absolute and without exception; others think that in rare cases the immunity is not yet present with the appearance of the chancre. It can, however, only be in the first days of the chancre's existence, before the development of any notable adenopathy, that the chancre is reinoculable.

In 1882 Bumm said: "In general the syphilitic chancre is not auto-inoculable, because the experiment is tried at a period when the general infection has already taken place. If we take for the inoculation fluid from a chancre eight days old, the bearer is already in the fourth week of his infection. The virus inoculated will take from two to three weeks to develop, a time during which the organism will be completely infected by the original chancre: hence the abortion of the chancre by inoculation. However, in making the inoculation early, and at a distance from the primary chancre, a result might be obtained."

Jullien admits that, in the early days of evolution of the chancre, general infection has not taken place, and positive inoculation is possible.

Lasch (*Archiv für Derm.*, 1891) says that before the appearance of the roseola it is possible to inoculate the bearer of a chancre with the secretion of his chancre.

Tarnowsky has shown as a possible source of error, that a simple irritation in some syphilitics may determine a papular lesion of chancre-like appearance, which he calls a "pseudo-indurated chancre." He even believes that this experimental irritation can be the means of discovering a latent syphilis in a given individual.

Lasch declares that the auto-inoculation does not in most cases produce a second infection, but calls forth the development of papular lesions some days before the roseola shows itself.

It is thus seen that the question of the exact début of immunity is difficult to determine experimentally, and many experiments, the author thinks, will still be necessary to settle the point.

As to the clinical side of the question, it seems that in certain cases, after syphilitic virus has penetrated the system, subsequent acts of coitus with an

infected person during the inoculation of the first chancre can equally result in the production of specific chancres.

It is evident that in such cases immunity could not be established during the incubation of the first chancre.

Thus the conclusion is reached that immunity is not necessarily constituted during the incubation of the chancre.

Some observations are given of chancres appearing in succession, separated by long intervals of time. Such instances are rare. Also in rare cases a chancre can itself produce reinoculation either spontaneously, by contact, or accidentally, by transportation of the virus to a distant region of the body.

In answer, then, to the question at what moment is syphilitic immunity established, the author believes the following conclusions are warrantable:

1. Syphilitic immunity is present from the very incubation period of the chancre, but it may fail to be established—often during the first days of this stage, occasionally during its whole duration.

2. In the rule, syphilitic immunity is established at the time of the appearance of the chancre. However, it is possible that it occasionally fails, at least during the first days of the evolution of the chancre and before symptomatic adenopathy. The bubo once developed, immunity is accomplished, and, by the time constitutional disturbances appear, it has already a certain age.

The question next to be considered is whether the immunity lasts during the whole existence of the disease. Careful examination of cases of supposed reinoculation or reinfection will serve to show whether cessation of immunity is not of pure hypothesis.

Instances of reinfection to the number of 148 have been collected, but the determination of their exact value is not so slight a matter.

The writer has analyzed all the published cases in the light of our present knowledge of the chancre *redux*, pseudo-chancres, chancroïdes, chancrelles, and late eruptions similar to those of the secondary period, and concludes that the law of Ricord is still to-day as legitimate as when first formulated. It is regarded as an absolute rule that syphilis does not double itself. Exceptions may be seen in extremely rare instances: reinfection is a possibility; but the author is far from admitting all the published cases. In fact, out of the 148 published instances he considers only nine valid, four of them being Dr. Taylor's cases—1876, 1883, 1885, and 1890. The remaining five, though worthy, are of Delestre, Gascoyne, Caspary, Pellizari, and Hutchinson.

Even this number, it is thought, might be reduced by searching inquiry.

As a result of this study, the author concludes that, when syphilitic immunity has been once constituted, it persists during the whole existence of the bearer, and, if Ricord's law is susceptible of exceptions, they must be extremely rare.

As to the immunity of hereditary syphilitics, in principle it is absolute. However, observations have been published contrary to this law. Among those who believe in the possibility of reinfection for hereditary syphilitics are mentioned Hutchinson, Lee, Merkel, Boeck, Rinecker, and Taylor.

Here, again, the observation of the last-mentioned writer is given promi-

nent notice, and is thought to be the only one in the list which merits to be retained.

The natural immunity enjoyed by certain individuals is not discussed, neither is Colles's law giving immunity to mothers who nurse their infants, rendered syphilitic by the father alone. CHARLES W. ALLEN.

A Case of Actinomycosis of the Face. MM. J. DARIER et G. GAUTIER. (*Annales de Dermatologie et de Syphiligraphie*, June, 1891.)

These authors report an interesting case of this rare disease, the treatment of which proved as brilliant in its results as it was original in its conception.

The patient was aged 24, a native of Prussia, and had lived in Paris seven years. The disease, the etiology of which could not be definitely traced, had first appeared nine months previously. The lesion occupied almost the entire right cheek, extending from the inferior border to the orbit above, limited on the inner side by the nasal furrow, and arrested below at a line corresponding to the upper border of the inferior maxillary and extending over the entire cheek-bone. The surface was of a reddish violet, of the color of certain forms of lupus, and covered in part by scales. The lesion was somewhat elevated and studded with half a dozen hemispherical elevations or nipples of about one centimetre in diameter, some of them ulcerated at the summit and covered with crusts.

The diagnosis was established by the abundant presence in the pus of minute grains of actinomycosis, each drop of pus containing from 10 to 15 of these minute bodies.

M. Gautier, having tried, without success, simple electrolysis, resorted to the application of the electro-chemical treatment, of which he is the originator.

The method is based upon the decomposition of a solution of iodide of potassium $\frac{1}{10}$, in living tissues, into iodine and potassium by the galvanic current. In order to obtain this result M. Gautier, in the present case, introduced two platinum needles in the nodules of the tissue, and by means of a syringe injected, every minute during the operation, a few drops of the solution. The two needles were connected with the two poles of a battery. The treatment, which was under chloroform, consisted of 3 séances, 20 minutes each, at intervals of 8 days, with an intensity of 50 milliampères.

The patient being enceinte, the treatment was interrupted for fear of compromising the natural evolution of the pregnancy. Six weeks after her accouchement a final treatment was given, with the result of accomplishing what is apparently a complete cure.

The Ancient Treatment of Syphilis. (*Annales de Dermatologie et de Syphiligraphie*, June, 1891.)

From Dr. Feullard's review of Paul Bru's work, entitled *Histoire de Bicêtre*, we extract the following curious account of the treatment of venereal diseases practised at the Bicêtre Hospital in the seventeenth and eighteenth centuries. The Hôtel-Dieu refused to treat syphilitics, exception being made only in the case of pregnant syphilitic women; and all other syphilitics, men or women, were compelled to go to the Bicêtre, which, by act of Parliament, 1690, was ordered to receive and care for them. The men were lodged in the Saint-Eustache, the women in the Misericorde.

Saint-Eustache consisted of five wards: one on the ground floor, the bath ward, containing a dozen baths, each sufficiently large to receive four men;

on the first floor, the medical ward, with 26 single beds: upon the second floor, on the right, was *la glacière*, the waiting ward for those who were to be subjected to the grand cure, and where the patients slept in large beds, six, eight, sometimes ten, together, according to the needs of the service: on the same floor, on the left, was the infirmary, with 24 single beds. La Misericorde consisted of nine wards, arranged like those of the men.

The patients were treated in series whenever the surgeons would or could give them attention, and they waited for months, sometimes an entire year, for the moment of treatment. Every eight weeks a batch of patients, consisting of 52 men and 50 women, were called to undergo the treatment, the duration of which was invariably fixed at six weeks, at the end of which 15 days were allowed for convalescence. They were then compelled to leave, whether cured or not.

The regulation of 1781, cited by M. Bru, gives the details of the treatment, which may be characterized as barbarous:

"The Saturday after the notification, all the patients were bled: the second morning afterward they were purged, and during the nine following days the pupils in surgery made them take baths of two hours' duration in enormous bath-tubs, where four patients at a time where obliged to plunge: one party entered the baths at 3 o'clock in the morning and remained until 5: another from 6 to 8 o'clock: the third from 8 to 10 o'clock. On the seventh day of the baths the 52 men, and on the following morning the 50 women, were conducted to the church, in order to make confession. After having purged their souls, their bodies were purged a second time. Then began the frictions administered according to the temperament of the patient: ordinarily they were continued 28 days. Those who were not undergoing the treatment were employed to rub those who were. Twice each day the surgical students made the necessary dressings ordered by the surgeon at his visit. The frictions being finally terminated, the patients were again purged two times and then declared cured."

"Crowded in warm wards, badly ventilated, and wanting proper nourishment, these unfortunates offered a favorable soil for the explosion of the terrible accidents of hydrargyrism. The mortality was little by little increased to the formidable proportion of 46 per 100 in 1792. At this epoch these veritable tortures ceased, as the treatment of venereal diseases was transferred to the hospital installed in the convent of the Capuchins, the Hôpital du Midi."

A Case of Tuberculosis of the Glans Penis, with Remarks concerning the Conveyance of Tuberculosis through Sexual Intercourse. PROF. P. KRASKE, Freiburg. (*Ziegler's Beiträge zur pathologischen Anatomie und zur allgemeinen Pathologie*, 4 Band, Zweites Heft.)

The patient with this unique affection of the glans penis was a man aged forty-nine years, who presented himself at the Freiburg Clinic with two irregularly shaped ulcers, which are well shown in an accompanying chromo-lithograph. The base of the ulcers had a yellow, cheesy appearance, with here and there a tendency to the formation of granulations, yielding a thin secretion. The edges of the ulcers were undermined, communicating with each other.

The peculiar appearance of the lesions led the author to exclude venereal ulcerations and carcinoma, and to consider the possibility of a tubercular affection. A careful examination of the patient failed to reveal any evidence of

present or past tuberculosis. The urine was clear, and failed by repeated examinations to show the presence of tubercle bacilli; further, the prostate, the epididymis, and testicles were healthy.

His first wife, who had given birth to several healthy children, had died of a cardiac affection, while his present wife was quite healthy, and had ten weeks previously given birth to a sound child.

The patient stated that the affection began three months previously without pain. He denied the possibility of an infection from intercourse, as he had only had connection with his wife, and his last intercourse with her dated several months before the onset of his local trouble.

An attempt was made to remove the ulcer without sacrificing the glans penis, but it was found to extend well through the body of the glans, rendering an amputation necessary.

The wound healed in ten days after the operation.

A microscopic examination of the excised tissue confirmed the clinical diagnosis, as both typical giant cells and numerous bacilli were found. The surface of the glans was less affected than the deeper tissue, showing apparently that the affection had taken its origin from beneath, and not as a surface infection, as was at first believed. A careful examination of the wife of the patient was made for local or general tuberculosis, with a negative result. The author is forced to the conclusion that the local trouble resulted from an infection through the blood rather than from a local inoculation.

The cases of tuberculosis of the urethra and meatus, which have been heretofore reported, have resulted from a descending tuberculosis of the genital apparatus or from the bacilli contained in the urine.

The Methodic Treatment of Gonorrhœa. DR. PAUL THIERY. (*Annales des Mal. des Organes Genito-urinaires.*)

In an exhaustive article upon the methodic treatment of regular uncomplicated genorrhœa in men, Dr. Thiery first calls attention to the generally unsatisfactory results of the classic modes of treatment and the positively pernicious effects of certain agents, such as pyoktannin, etc., which have been recently introduced. He insists that there is no unique, routine treatment applicable to all cases, but that procedures of treatment should vary with the stage of the disease and the period at which the patient comes under observation. He then exposes in detail the method which, in his opinion, constitutes the most rational and successful treatment.

To the question, What should be called a cure of gonorrhœa? he responds that we cannot regard as a cure the more or less rapid sedation of the inflammatory phenomena which takes place under the influence of almost all of the treatments at present employed, the result of which is to reduce the abundant discharge to a gleet, which substitutes a subacute for an acute stage, and which prolongs the duration of the affection and establishes chronicity. The *desiderata* of cure are: (1) to produce promptly a sedation of the inflammatory and painful phenomena; (2) to reduce, then to suppress, the discharge; (3) to prevent a relapse; (4) to accord to this treatment the smallest possible minimum of duration.

The class of cases especially considered are those of regular, uncomplicated gonorrhœa, which, 1st, occurs in a patient for the first time; or, 2d, occurs in a patient previously affected, whose former attack has left no trace or complication (stricture, etc.); 3d, which exhibits from the first an acute, not

torpid, course, and, whatever may be the intensity of the acute phenomena, they are limited to the urethra and without complication (cystitis, orchitis, etc.); 4th, which occurs in a patient in good health, and who presents no general or local damage; 5th, which has not been treated, or, as rarely happens, has been subjected from the first to a rational or regular treatment.

Accepting absolutely the theory of the specific nature of gonorrhœa, a rational treatment, according to the author, must be essentially parasiticidic. He admits, however, that the gonorrhœal discharge may be perpetuated, after the diminution or entire disappearance of the parasitic element, by certain alterations in the mucus surfaces, to the prevention of which care should be particularly directed.

The author recognizes in gonorrhœa several periods, or stages, each one amenable to a special treatment. The *first period*, from the first to the third day; at first absence of symptoms, then sensation of heat, slight pain on micturition, then the appearance of a thin mucous secretion and gonococci not abundant. *Second period, or acute stage*, from the third to the tenth day, heat, sharp pain on micturition, redness of canal and meatus; abundant, thick, puriform, greenish-yellow discharge, gonococci very abundant. *Third period, or decline*, pain slight or nil on micturition, the inflammation abated, pus diminished, sero-purulent, then sero-mucous, duration of period from fifteenth day to end of first month; may end, though rarely, in complete cure, or pass into next stage. *Fourth period*, slight sero-purulent discharge, sometimes none at all, although may relapse from neglect of régime, gonococci still exist in purulent secretion, but are rare; may endure for months and become chronic. *Fifth period*, inveterate gleet, discharge almost nothing, perhaps non-contagious, gonococci absent or excessively rare, may endure for years or indefinitely.

A general treatment, which may be termed the hygiene of blennorrhagics, applicable to all the stages, but which is more formally indicated in the first three stages, consists of rest, the avoidance of stimulating articles of food and drink, venereal indulgence, etc.

As regards special treatment, two methods may be employed. That which may be termed the intensive or abortive method is only applicable to the first stage; the rapid method, consisting of injections, is applicable to the second stage; finally, the slow method, applicable to patients who in the first and second stages refuse both the abortive treatment and injections, and to the third stage.

The abortive method gives marvellous results, but it has three inconveniences: (1) It demands a careful operator, and cannot be intrusted to the patient; (2) it is very painful; (3) it is only applicable in the beginning, within the first twenty-four hours, when the patient rarely comes under observation.

The following are the details of its employment: The patient, after having urinated, should be placed in a recumbent position, the urethra should be washed with a concentrated boric solution, which may be obtained by the addition of a small quantity of magnesia to the ordinary saturated solution. A preliminary injection of cocoaine may be used to alleviate the pain. A solution of nitrate of silver 1:40, or even 1:30, if perfect local anæsthesia has been secured, may be employed. This is carried, by means of the instillating syringe of Guyon, to the cul-de-sac of the bulb. At this point a few drops are injected, then, withdrawing little by little the instillator, the fluid is

slowly injected so that the walls of the canal may be freely bathed in the caustic. The instillator having been withdrawn, the patient retains the injection as long as the pain will permit him to do so. A quite intense reaction follows, and the abortion may oftentimes be completed by a single injection. He inclines generally to repeat the injection the same evening with a solution of 1 : 50, and another the following morning. Unless a cure is then obtained, it cannot be hoped for, and it will then be necessary to resort to the injections appropriate to the second stage.

SECOND PERIOD.—The patient may refuse the abortive treatment or may not present himself until it is too late to employ it. Ordinarily he does not come under observation until from the third to the tenth day. Two procedures may then be employed—one, the classic treatment, by diuretics and balsamics, which is slow, necessitating a prolonged use ; the other, by antiseptic injections, demanding special care, but which procures a much more rapid cure.

The first method consists in administering, during the entire second stage, 3 to 5 grams of bicarbonate of sodium a day, and prescribing baths, with a suitable regimen, until the acute symptoms subside. With the accession of the third stage the bicarbonate of sodium is discontinued and the following is ordered :

℞ Pulv. copaibæ,
Pulv. cubebæ, ... āā 60 gm.
Magnesiæ, ... q. s.

Ut ft. electuary.—Take each day 6 boluses, large as a nut, of this preparation.

To avoid the diarrhœa and gastric pains sometimes produced, it should be taken during the repast. The principal inconvenience of this treatment is its prolonged duration, which is on the average fifteen days of diuretics and fifteen to twenty days of balsamics.

ANTISEPTIC INJECTIONS constitute the treatment of choice. The classic injections of sulphate of copper, of bismuth, etc., etc., are proscribed by the author, who has for a long time employed almost exclusively antiseptic injections of iodoform in oil or glycerin. Iodoform appears to him to respond better than any other agent to the three *desiderata:* innocuousness, analgesia, antisepsis. Its disagreeable odor may be masked by the addition of coumarin, eucalyptus, vanillin, coffee, etc. His experience with this agent has enabled him to demonstrate :

1st. That the average duration of treatment has been about twelve days, a period which it is possible to reduce by increasing the number of injections.

2d. That the pain disappeared rapidly after the first injections, a constant fact in all cases.

3d. That the cure was the more rapid the earlier the injections were begun, and that in the most recent cases, not subjected to previous treatment, the duration of the treatment was much less than the average indicated above.

The following is the injection recommended :

℞ Pure pulverized iodoform, ... 10 gm.
Oil of sweet almonds or glycerin, ... 60 gm.
Any disinfecting substance, ... q. s.
M.

With this three injections of about eight grams each should be made every day after urination, the patient in a recumbent position. The injection should be retained from ten to twenty minutes. The first injections should be made by the surgeon himself. The injection treatment should be continued until after the complete disappearance of the discharge, and, as a measure of precaution to prevent relapse, a few supplementary injections should be employed.

THIRD PERIOD.—In this stage the balsamics are especially indicated. Oil of santal possesses a remarkable efficacy, but it is necessary to administer large doses, ten to fifteen capsules daily, and the remedy is costly. The treatment for this stage may thus be formulated: Let the discharge diminish under the influence of balsamics and without any local treatment whatever. Should the affection date back two or three months, and the discharge be slight or almost nothing, have recourse to instillations. Should the patient come under observation in the *fourth period* we must still have recourse to instillations, with a quasi-certainty of success. Finally, we may have to do with a gleet, not only prolonged, but inveterate and chronic, and in such cases instillations of nitrate of silver constitute the only procedure which has given remarkable results; they constitute the surgical arsenal of chronic gleet; properly employed and conjoined with a suitable regimen, the effects are marvellous.

The instillations should be made every two or three days, as a general rule every three days, and more frequently if toward the fourth or fifth séance the looked-for improvement is not produced. As a general rule, anterior instillations are made; in rebellious cases it may be necessary to carry them behind the bulbous portion.

The necessary number of instillations varies within wide limits. In simple cases eight or ten usually suffice; in rebellious cases twenty may be required; ordinarily the patient is informed that about twelve will be necessary, comprising six weeks of treatment, the first ten being given every two or three days, the eleventh after an interval of eight days, and the last after ten or fifteen days' intervals, in order to insure a maintenance of the cure.

The instillations should not be made indifferently with the same strength of solution; they should be divided into two series of six instillations each: the first six of a strength of 1:50; two drops of this solution should be used at the first instillation, and the dose gradually increased by one drop at each new instillation. After the sixth, the instillation should be recommenced with two drops of a solution of the strength of 1:30, increasing the dose one drop each new instillation to the twelfth, inclusive. During the entire duration of the treatment the patient should avoid long walks, horseback-riding, and wear a suspensory bandage. In several thousand instillations the author has observed only one case of orchitis attributable to the treatment.

In conclusion the practical indications of the treatment of gonorrhœa are formulated as follows:

1st Period (second or third day)—Abortive injections of nitrate of silver.

2d Period (third to tenth day, about)—Injection of iodoform in oil or bicarbonate of soda baths.

3d Period (tenth to fifteenth day, to the end of the first month)—Balsamics.

4th Period (second to third month)—Instillations of nitrate of silver.

5th Period (after third or fourth month)—Instillations with nitrate of silver.

Objectively cured, the patient should still continue a special régime, and during at least one month thereafter alcoholic or venereal abuse should be prohibited with a view of maintaining a permanent cure.

Prostatics and their Treatment. PROF. GUYON. (*Journal de Médecine de Paris.*)

In prostatitis three periods may be distinguished. In the first are congestive phenomena, which may be almost alone encountered; the two characteristic features of its symptomatology are frequent nocturnal calls and polyuria. In the second period there is incomplete retention; the patient does not completely empty his bladder, and a certain quantity remains stagnant in the *bas fond*. Finally, the third period is established when to the retention there is added a distention of the vesical reservoir, the muscular contractility of which is profoundly involved, and which rests inert; the consequence is incontinence from overflow.

Each of these periods demands a particular treatment. In the first, the congestive phenomena are principally to be combated. We know that the morbid symptoms are chiefly nocturnal and occasioned by repose in bed; it will therefore be desirable that patients remain in bed the least time possible, from seven to eight hours on the average. Again, it is well for them to arise two or three times during the night and walk a few minutes in their chamber. The sitting position should likewise not be prolonged. On this account long railroad journeys are particularly harmful and often precipitate crises of complete retention; the same is true of prolonged repasts.

Among remedial measures, a medication directed toward the prevention of constipation figures in the first line. Internally, a few medicaments; narcotics, calmatives, are especially to be proscribed; administered by the mouth or in the form of suppositories, they may for a few nights attenuate the frequency of the desires to urinate, but it is an artificial calm, attended with risk of provoking or increasing the congestive condition. On the other hand, there is one remedy, the iodide of sodium, which acts beneficially on the general system. We know that prostatics are atheromatous, and that this diathetic state is modified in a certain measure by the use of the iodides; 20 to 50 centigrammes each day is sufficient.

All local therapy addressed to the prostate or the bladder is interdicted in this stage.

The second period of prostatism is characterized by the incomplete emptying of the bladder: the dominant treatment should therefore be evacuating catheterism. It is necessary to supply the place of the insufficient contraction by assuring a regular drainage and evacuation. To get the bladder dry frequently and in a methodic manner is the first act in the treatment of prostatics in the second stage. This precaution suffices when neither the bladder nor the upper passages are involved in inflammation or suppuration. It is most important. Often we see old men neglecting, not only antisepsis, but the ordinary rules of cleanliness, carrying their catheter in the pocket or the hat, moistening it with saliva in order to lubricate it. Nevertheless they preserve their urine clear and limpid, and their bladder is not inflamed. The explanation of the fact is that, while they introduce septic elements in the bladder, they allow them to immediately escape: there is no stagnation, and these organisms cannot develop. It is none the less true that such carelessness is dangerous, that the bladder will be sooner or later inoculated, and the more rapidly the less precaution taken.

When there is vesical suppuration, antiseptics are necessary: the old ones are still the best: boric acid in the ordinary simple cases: nitrate of silver in those where suppuration is obstinate. Washing out the bladder demands for its efficacy a certain degree of mechanical action: it should lift up and remove the mucosities and deposits accumulated in irregular bladders, and not constitute a sort of irrigation which passes beneath the mucosities, without detaching them.

When to incomplete retentions there is superadded vesical distention, the third stage of prostatism is established, surgical treatment is indicated, but it is attended with dangers which exist in but a feeble degree in the second stage: also recourse should be had to medical treatment, which is of the highest importance. Insalivation and deglutition are difficult: it is therefore necessary to resort to liquid or semi-solid aliments, such as purées of meat, eggs, milk, etc. Tonics, bitters, quinine, colombo should be prescribed, good wine may be freely used, and sometimes, even when the patient needs stimulants, cognac or rum. Finally, living in the open air, moderate exercise, and especially cutaneous excitement, dry frictions, constitute almost the entire medication appropriate.

As regards catheterism at this stage, it requires the most delicate decision. Intervention is perilous, and a certain proportion of patients abandoned to themselves sometimes survive for some time. On the other hand, many of them who have the bladder evacuated retrograde toward the second stage, and have better health. If renal insufficiency is certainly demonstrated, it is much better to entirely abstain: in other cases the catheter may be used, but taking infinite precautions.

The rules of catheterism have been elsewhere exposed. It is understood that we should not proceed to a rapid evacuation: to empty at once a distended bladder is to expose the patient to the danger of a vesical hemorrhage: it is necessary to desist as soon as the urine does not escape in a jet, but falls in dribbling drop by drop. It is especially necessary that the strictest antiseptic precautions should be employed, the slightest error may be followed by rapidly fatal infectious accidents. Antiseptics should likewise be introduced within the bladder: a solution of boric acid, five-per-cent. constitutes the best preparation. A certain quantity of urine is evacuated, which is replaced by a somewhat less, but quite considerable, quantity, of the boric solution, which may be repeated several times in succession.

"Arsenic as a Drug." J. HUTCHINSON. (*British Medical Journal*, June 6th, 1891: *Medical Chronicle.*)

In this paper Mr. Hutchinson sets forth views founded on a long and large experience in the use of arsenic. He is doubtful whether it should be regarded as a tonic, for, as a rule, patients are not improved in general health by it, especially if full doses be given. They feel languid and depressed, and at times lose flesh, improving when the remedy is given up. Yet in certain morbid conditions the health improves and a tonic effect is produced, especially if small doses be given, but this may be due to the removal of the morbid condition.

It may produce many cutaneous troubles:—

1. The skin may become brown and muddy-looking, dry and harsh on the trunk and limbs generally, although palms and soles may perspire.

The pigmentation may be almost as great as in Addison's disease, and scaly patches may occur on knuckles, elbows, and knees.

2. A common result of disturbed skin nutrition is seen in affection of the palms and soles only, which become dry: corns may form, and in rare cases these corns may pass into epithelial cancer. Sometimes the palms and soles burn, itch, and perspire.

3. Herpes zoster may follow after the drug has been used some time.

It may easily influence the nervous system, leading to peripheral neuritis, with consequent numbness and tingling, especially in the lower extremities, and local and unsymmetrical paralyses. Its influence is producing herpes zoster is an example of its effect on the peripheral nerves. Mr. Hutchinson records a case in which a patient who had taken continuously large doses of arsenic for more than a year became emaciated, staggered in his gait, and and was partially paraplegic. After violent convulsive seizures he passed into a state of coma and died.

He has seen several others in which the habitual use of arsenic seemed to cause or increase the liability of epileptic attacks, and one or two others in which partial paraplegia was connected with its use.

It gives his experience of its use in the following skin diseases:

1. *Pemphigus.*—After arsenic is given, as a rule, no fresh bullæ appear. There are a few exceptions to this, especially in elderly subjects, and where there is disease of the mucous membrane of the mouth.

2. *Dermatitis Herpetiformis.* Here arsenic is considered by Mr. Hutchinson as a certain and prompt cure.

3. *Herpes.*—In rare cases herpes occurs over and over again in the same locality. Recurrence is suspended during the continuance of arsenic. Recurrent herpes on the genitals, lips, and sometimes inside the mouth are under the control of the drug if it be steadily continued. Recurrence may again occur when it is suspended. Mr. Hutchinson has had some most remarkable cases of liability to herpes in the mouth, returning every month for one or more years, in which the liability ceased immediately the drug was given.

4. *Eczema.*—Here it is of doubtful value. In large doses it seems to make the eruption worse. In small doses it may not hinder the cure, but it is questionable whether it materially helps it.

5. *Erythema.*—Mr. Hutchinson records the case of a boy who suffered with peculiar erythematous eruption on limbs and trunk, which never yielded till arsenic was given, when it quickly went.

6. *Lichen Planus.*—The effects of arsenic are by no means uniform in this ailment. In some cases it seemed to do much good; in others it got worse.

7. *Psoriasis.* The effect of arsenic is as definite here as in pemphigus, but not so immediate. Sometimes its effects are first manifested by the patches taking on a congested condition and becoming very irritable. In a large majority of cases it will cause the eruption almost wholly to disappear, but it seldom or never brings about a complete cure. Its efficiency and safety are in ratio with the youth of the patient.

In the young, arsenic is usually well borne, but Mr. Hutchinson has formed an unfavorable opinion as to its influence on elderly persons, and unless the disease imperatively demands it he never prescribes it for them.

He thinks caution is especially necessary if symptoms of nerve degeneration are present.

As indications to its discontinuance, Mr. Hutchinson looks upon dryness, numbness or tingling of the palms or soles, numbness of any particular part of the skin, or loss of flesh as more important than irritation of the conjunctiva. Liability to diarrhœa or irritation of the bladder are other signs of its disagreement.

Gonorrhœal Meningitis and Optic Neuritis. DR. PANAS. (*La Semaine Médicale*, 1890.)

Dr. Panas relates the history of a man of twenty-nine, who, after a gonorrhœa, with acute symptoms lasting four months, and while some discharge was still present, suddenly lost the sight of the right eye. There was a history of a decided chill, after exposure to cold, with subsequent severe headache lasting for ten days, and compelling patient to keep his room until the day before the sight was lost. On examination the ophthalmoscope showed an optic neuritis of a severe type passing into atrophy. The opposite eye was also found to be in a state of mild neuritis, but here the vision was still perfect. It was thought by the author that a gonorrhœal meningitis had been present, causing the severe pain in the head, and that the optic neuritis was a direct effect of the meningeal inflammation.

CHARLES W. ALLEN.

Antisepsis of the Urethra. MM. EMILE PETIT et N. M. WASSERMAN. (*Annales des Mal. Genito-Urinaires*, July, 1891.)

Antisepsis of the urethra comprehends two indications (1) disinfection of instruments; (2) asepsis of the urinary passages.

The means of securing the first indication have been fully elucidated, but, unfortunately, for the second, measures absolutely trustworthy have not been elaborated; the conclusions arrived at by Lavaux and others give to the surgeon an assurance which in many cases may be prejudicial to patients.

Antisepsis of the urinary passages has been studied only from a clinical point, and two methods have been employed—(1) administration of internal medicaments and (2) direct local measures.

Former experiments led to the belief that the internal administration of salol might suffice to obtain a complete antisepsis of the urinary passages; but the later investigations of Albarran have shown that the urine of patients who have absorbed even large quantities of this drug have no marked bactericide power and contain a large number of pathogenic microbes.

As to the second method (direct antisepsis) no bacteriological examination of the canal has been made after the employment of local antiseptics, and consequently the conclusions of M. Lavaux derived from his experiments in washings of the urethra, not being based upon bacteriological examinations, are, *à priori*, without value. The authors have experimented upon eleven patients, taken indifferently from the ward and out-patient service, presenting diverse affections; prostatic hypertrophy, stricture of the urethra, chronic urethritis, cystitis, tumors of the bladder, etc.

The details of the procedures for inoculating tubes of bouillon with the contents of the canal after thorough irrigation with water sterilized by boiling, four-per-cent. solution of boric acid, and solution of nitrate of silver 1 per 1,000. The result was that they found at the end of a week numerous micro-

organisms in the tubes inoculated after washing with nitrate of silver, as well as in those inoculated after washing with sterilized water and boric solution.

They conclude that it is inadmissible to affirm that prolonged irrigations (thirty minutes), such as are habitually made in ordinary practice with antiseptic solutions not injurious to the uninary passages, effect a complete antisepsis of the urethra.

Experiments were not made with antiseptics more powerful than those indicated, as they would prove too painful. It may be possible to secure a *complete antisepsis* of the urethra by employing several times in succession *strong antiseptic solutions*, but *by a single washing with the solutions habitually employed in urinary surgery (boric acid four-per-cent, nitrate of silver* 1 *per* 1,000) *one cannot obtain a complete antisepsis of the infected urethra.*

Antidotal and Bactericidal Properties of Fresh Urine. DR. TERRY. (The *Dietetic Gazette*, June, 1891.)

The author writes that fifty years ago he discovered in fresh urine an excellent antidote for the bites and stings of insects and bees, and has since used it on many occasions, and always with the most happy results. He attributes the power of the remedy to urea. It is interesting to note in this connection that Richter has found (*Arch. für Hyg.*, No. 1, 1891):

1. That fresh urine shows bactericidal properties toward charbon, cholera, and in a less marked degree typhoid fever.

2. These properties are due to the presence of acid phosphate of lime.

3. The urine loses almost completely its bactericidal properties as soon as it is neutralized.

4. Boiling, which transforms the acid phosphate into an ammonia phosphate, destroys the bactericidal properties of the urine.

5. Alongside of the acid phosphates, there exist other substances which contribute to the bactericidal properties of the urine. It is not known whether these substances are chlorides, concentrated neutral phosphates, or something else. CHARLES W. ALLEN.

Danger of Cocaine in Urethral Surgery. DR. GLENN. (*Southern Practitioner*, April, 1891.)

Dr. Glenn presents the following conclusions:

1. Cocaine is a most potent and wonderful local anodine, but not void of danger.

2. Its use should be positively forbidden in the recently cut or denuded urethra.

3. Prepared after the manner of Glück (with phenol), it is equally unsafe to apply to an abraded urethra.

4. The use of cocaine in the urethra is attended with more risk than when applied to any other part of the body. CHARLES W. ALLEN.

Diabetes and Syphilis. DR. SOUROUKTCHI. (*Wratch*, No. 1, 1891.)

The writer reports an instance of diabetes insipidus of syphilitic origin, making only the third observation of the kind to be found in literature. The patient, a young man of twenty-five, had an extreme thirst, and passed daily about six litres of urine, having a specific gravity of 1,004. There was no

sugar nor albumin present, and syphilis was not suspected till mucous patches made their appearance some ten days after admission to hospital.

One month after anti-syphilitic treatment was instituted, the diabetic symptoms completely disappeared, excessive hunger and thirst were no longer present, and the other symptoms of syphilis (headache, etc.) ceased, while the patient gained in weight and remained well for over a year after leaving the hospital. Charles W. Allen.

Gonococci. Drs. Vibert and Bordas. (*La Méd. Moderne*, Nov. 13th, 1890; Jan. 1st, 1891; and *Journ. des Mal. Cut.*, June, 1891.)

In the first article the authors attempt to show that the gonococcus has no value as a diagnostic sign in medico-legal cases where the nature of a vulvitis is to be determined. They found, to all appearances, identical organisms in six instances where blennorrhagia in young girls was attributable to other than venereal cause. In the second paper are reported the successful attempts of the authors to cultivate the gonococcus. Positive results were obtained upon bouillon, agar, and potato. The cultivations showed diplococci in all respects similar to the gonococci. Thus it would appear that cultivation is not sufficient to make the diagnosis absolute. If the observations of different authors are compared it will be seen that they are not in accord either as to the best media for cultivations, the proper temperature, the length of time required, or the appearance of the colonies of cocci after they have developed. In the author's own hands the results have not been uniform.

They are, hence, of opinion that in the present state of knowledge it is impossible to recognize the gonococcus with absolute certainty, and to distinguish it from other micrococci to be found in vaginal secretions. In the last article, upon "the gonococcus in legal medicine," it is stated that in the authors' experience only one variety of micrococcus is found in the acute vulvitis of little girls; and this presents all the features of the gonococcus.

In conclusion, they feel justified in the statment that at the present time the question of the gonococcus is far from being solved with that complete certainty which forensic medicine requires, and believe that in no case is the expert authorized in affirming the blennorrhagic nature of a vulvitis based upon a bacteriological examination, no matter how complete.

Charles W. Allen.

Book Reviews.

Pathologie et Traitement des Maladies de la Peau. Leçons à l'Usage des Médecins Practiciens et des Etudiants, par le Prof. Moriz Kaposi. Traduction, avec Notes et Additions, par MM. Ernest Besnier, Membre de l'Académie de Médecine, Médecin de l'Hôpital Saint-Louis, et Adrien Doyon, Correspondant de l'Académie de Médecine, etc. Second Edition Française avec Figures Noires et en Couleurs, Tome Second. Paris: G. Masson, Editeur, Librairie de l'Académie de Médecine, 1891.

Since the passing away of Hebra, the creator of the Vienna School of Dermatology, M. Kaposi, his legitimate successor, has been regarded as the most distinguished representative of this school. His work on the Pathology and Treatment of Skin Diseases, while reflecting the views of Hebra, was at the

same time largely original, and now, after the lapse of several years since its first publication, it still ranks as the most valuable and practical treatise on skin diseases in the German language.

The chief demerit of Kaposi's work is that it is too exclusively National. While embodying a most able exposition of the doctrines of the Vienna school, scant recognition is given to the views of foreign dermatologists. His philosophy of therapeutics is dominated by an exclusive devotion to the theory of the local pathology of cutaneous diseases, entirely ignoring the older diathetic doctrines which connect many dermatoses with disorders of the general system.

In the notes and additions which accompany the translation of Kaposi's book into French, MM. Besnier and Doyon have done a good work by placing in juxtaposition the independent and often opposing doctrines of the Vienna and French schools of dermatology, as well as differences of treatment based upon such widely divergent etiological conceptions. While criticising fearlessly what seems to them erroneous in the system of Hebra, their discussions reflect a true scientific spirit and never surpass the limits of an honest independence of judgment.

The work of the editors has been by no means confined to a presentation, for purposes of contrast and comparison, of the fundamental differences in doctrine and therapeutics of the two schools; its chief value consists in the development and amplification of parts incompletely treated in the original text and in the exposition of subjects entirely new.

It must be admitted that Kaposi's book forms no exception to the fate imposed by the rapid march of science upon all works of a decade ago. Despite its great and undoubted excellence, it does not represent the actual state of dermatological science of to-day, and must be relegated to the position of a "back number." No greater compliment could be paid to the German author than this effort on the part of his French confrères to supplement and complete his work, by the addition of several hundred carefully written pages embodying an epitome of the progress made in every department of dermatology since the issue of the last German edition.

In addition to the valuable material supplied from their own personal knowledge and observation, they have placed under contribution the researches and investigations of dermatologists in all countries during the last ten years; every important work relating to the etiology, histological pathology, bacteriology, semeiology, and therapeutics of skin diseases has been examined and analyzed and a résumé of the results given.

The amount and painstaking character of the work contributed by the editors is surprising, and constitutes a new departure in medical authorship. In the ordinary conception of the relative importance of an original work, and the notes and emendations of its editor, the latter sink into quite a subordinate position, but in the French edition of Kaposi's book this relative value is reversed. The notes and additions of MM. Besnier and Doyon far surpass in importance and value the original text. The alphabetical table of the added material, which follows the general index, contains no less than twenty-two pages in double columns. Many new and rare diseases not treated in the original receive full and adequate consideration at the hands of the editors; and to many groups of diseases is given a much larger space than is accorded to them in the German work; thus Kaposi devotes four or five pages to alopecia

areata, while there are thirty pages of added matter; to five pages of alopecia furfuracea there are ten pages of notes. The ten pages devoted to lupus erythematosus are supplemented by thirty pages of notes, thirty pages of lupus by nearly fifty pages; and while the subject of leprosy embraces twenty-one pages in the original, nearly fifty pages are devoted to its consideration in the notes.

The importance of the new material is not to be measured alone by its quantity; it is singularly free from verbosity and diffuseness. The greater part of it is evidently the work of M. Besnier, and is characterized by that clearness and conciseness of expression, that lucidity of explanation, and that analytic judgment which distinguish the writings of the eminent and accomplished teacher of the Saint-Louis Hospital. Especially in the department of treatment has the original work been improved and perfected. This subject has received the most careful consideration from one whose opportunities for clinical experience, commanding the rich resources of the Saint-Louis Hospital, have been unrivalled. The indications are pointed out with precision and clearness, and many new therapeutical agents and methods whose worth has been demonstrated by experience are recommended.

In laying down this work, one is tempted to ask why these notes and additions, so valuable from a scientific point of view, so systematically arranged and sufficient in extent to form a large volume, covering the entire field of dermatology, were not incorporated in a separate and original work. Evidently this question has been frequently demanded of the editors, who state in the preface to the second French edition that they have thought a work conceived on the plan which they have adopted would be most important "from the standpoint of the progress of pathology, the instruction of students, and the needs of general practice": they have therefore "reunited in the same book, at the same time, the teachings of the national school with the teachings given by foreign schools." In other words, they have endeavored to present a treatise which should be thoroughly international, in which the work and views of dermatologists of all countries should find full recognition and expression. In the language of M. Vidal, "it is a cosmopolitan treatise, a veritable monument of international science."

We have no hesitation in pronouncing the work, both from a scientific and practical point of view, the most valuable contribution which has been made to the modern literature of dermatology. P. A. M.

Die Litteratur über die venerischen Krankheiten, von den ersten Schriften über Syphilis aus dem Ende des fünfzehnten Jahrhunderts bis zum Jahre 1889. Systematisch zusammengestellt von J. K. Proksch. T. II. and III. Bonn: Verlag von Peter Hanstein, 1891.

In a notice of the first part of this monumental work we called attention to its scope and admirable arrangement.

The second volume embraces the literature of blennorrhagia, chancres, and buboes. The same systematic arrangement so admirably adapted to facilitate ready reference is followed. First are presented documents relating to the pathology and treatment of blennorrhagia in general, then articles treating of its sequelæ and complications, followed by a list of the publications upon stricture of the urethra, its symptoms, pathology, and treatment; diseases of the prostate, the urethral glands, the testicles, epididymitis, etc.; sterility,

balano-posthitis, rheumatism, blennorrhagia in women, endoscopy of the urethra and the bladder; the volume terminating with a review of the literature of chancre, bubo, condylomata acuminata, phimosis, and paraphimosis.

The third part is devoted to a consideration of the vast and varied literature of syphilis. No fewer than 750 pages are required for the enumeration of the titles of works upon this subject. The same methodic order characterizes the arrangement of the subjects: First, articles relating to the pathology of syphilis, its periods, forms, complications, and sequelæ; then the literature of syphilis of the different systems and organs of the body, classed separately. The list of publications on the therapy of syphilis is surprising in its variety and extent, the vast array of drugs and agencies drawn from the vegetable and mineral kingdoms, and the methods of treatment which have been recommended, but now obsolete, form a curious illustration of medical empiricism. The volume concludes with a list of the works upon hydrargyrosis.

We cannot too highly commend the scientific spirit and marvellous industry of the author in carrying to a successful conclusion a work involving so much labor and research.

Die Blennorrhöe der Sexualorgane und ihre Complicationen. Nach dem neuesten wissenschaftlichen Standpunkte und zahlreichen eigenen Studien und Untersuchungen dargestellt von Dr. ERNEST FINGER, Docent an der Universität in Wien. Zweite Auflage. Leipzig und Wien: Franz Deuticke, 1891.

The first edition of this work, which was noticed at some length in this journal, is well known in this country and Europe as one of the clearest and most scientific expositions of gonorrhœa in any language. An American translation published in Wood's Monographs has made the work more widely known and read in this country. The appearance of a second edition at this early date certainly attests to the popularity of the work. A number of additions have been made to bring the work up to date. The chapter on gonorrhœa in women has been enlarged and altered to correspond to the recent additions made to our knowledge of the subject. The author still adheres to his belief in a primary gonorrhœal vaginitis, notwithstanding the assertions of a number of recent investigators that it is always secondary to a cervical gonorrhœa. The extensive bibliography given with the first edition has been omitted, having been rendered superfluous by the appearance of Proksch's excellent bibliography of the venereal diseases. The work can certainly be commended as the most satisfactory with which we are acquainted.

Atlas der Cystoskopie. Von Dr. EMIL BURCKHARDT, Privat-Docent der Chirurgie und früherem Assistenzarzt der chirurgischen Klinik an der Universität Basel. Mit 24 Tafeln in Farbendruck. Basel: Benno Schwabe, Verlagsbuchhandlung, 1891.

Since the inspection of the bladder has been rendered possible and to some extent easily practicable through the instruments of Nitze and Leiter, a number of books have appeared describing the normal and pathological conditions seen. The work under consideration, however, is the first systematic attempt to portray in color the appearance observed. The author is to be con-

gratulated in possessing at the same time the necessary artistic and technical skill to successfully accomplish his task.

The Atlas contains twenty-four full-page plates in color, portraying fifty-seven endoscopic observations of the normal and diseased bladder. The sketches were made during the endoscopic observations, and no attempt was made by the author to render them clearer or more easily understood by subsequent changes. The use of cocaine was avoided in order to more perfectly preserve the natural color of the bladder.

The drawings are reproduced by chromo-lithography, and are certainly very beautiful examples of that art. The Atlas contains plates representing the appearance of the healthy bladder, of cystitis acute and chronic, hypertrophy of the prostate and its complications, tuberculosis of the bladder, tumors of the bladder, concretions in the bladder, foreign bodies in the bladder, injuries and fistulæ of the bladder, and diseases of the ureters.

The Atlas will certainly prove a useful guide, and can be honestly recommended to all interested in this new branch of surgery.

The mechanical execution of the work is the best and the price moderate.

Ueber die Behandlung von Lupus, Lepra und anderen Hautkrankheiten mittels Koch'scher Lymphe ("Tuberculin"). Von Prof. M. KAPOSI. Mit 2 lithographirten Tafeln und 1 Tabelle. Wien: Alfred Holder, 1891.

The author, in this work, gives a tabular record of the results obtained in the treatment of thirty-five cases of lupus of every variety, together with cases of lupus erythematosus, lepra, epithelioma, lymphoma pharyngis, syphilis, folliculitis exulcerans, and tuberculosis verrucosa cutis. The experiments were undertaken by himself and his assistants, and cover a period of three and one-half months, from the 29th of November, 1890, until the 13th of March, 1891.

To add to the scientific value of the investigation, all the patients were examined before and after the injections, relative to the condition of their internal organs; careful blood tests were made, and a number of histological examinations of lupus and other diseases, both before and after the local reaction, were made by Dr. Lukasiewicz. The details of many of these investigations have already been published in the medical journals.

The careful analysis of the cases and the scientific conclusions reached, by a man who has for so many years had such excellent opportunities for observing and treating lupus in its most destructive forms, cannot fail to be of interest and value.

Books and Journals Received.

Transactions of the 34th Annual Session of the Medical Association of the State of Missouri, a copy of which is before us, shows this association to be in a most flourishing condition, with a large membership, well organized, with a very complete array of standing and special committees. The papers presented at the last meeting were of an unusually high order of merit.

Wood's Medical and Surgical Monographs, Vol. XI., No. 1, for July, contains the three following interesting memoirs:

Hay Fever and Paroxysmal Sneezing, by Sir Morell Mackenzie, M.D.

Tuberculosis of the Bones and Joints, by Dr. Fedor Krause.

A Study of Malignant Disease of the Upper Air Tract, by F. H. Bosworth, M.D.

Post-Graduate Course of Lectures, Medical Faculty of University of Toronto, delivered December 17th, 18th, 19th, 1890.

Notes on Lichen Planus in Infants, by T. Colcott Fox, M.B., Physician to the Skin Department at Westminster Hospital.

On Urticaria in Infancy and Childhood, by T. Colcott Fox, M.B. (London), M.R.C.P.

Some Comments on Leprosy in its Contagio-Syphilitic and Vaccinal Aspects, by A. M. Brown, M.D.

Professor E. M. Crookshank on the History and Pathology of Vaccination, a Review.

La Lèpre en Nouvelle-Calédonie, par M. le Docteur M. A. Legrand ; avec une introduction par Prof. H. Leloir.

Le Lupus Vulgaire Erythematoïde, par le Prof. H. Leloir (with chromo-lithographic plate).

Des Affections Cutanées Pure en Hybrides, Determinées par l'Inoculation des Agents de la Suppuration, par le Prof. Leloir, of Lille.

La Tuberculose Cutanée, par le Docteur Georges Thibierge. Médecin des Hôpitaux de Paris.

Exposé des Ressources Thérapeutiques de Thermes de Luchon, par le Dr. P. Ferrari.

Traitement des Tumeurs Blanches, Emplâtres Mercuriels, Injections Modificatrices. Valeur relative des opérations et surtout des Resections, par le Dr. Lucas Championnière, Chirurgien de l'Hôpital Saint-Louis.

Lepra mit besonderer Berücksichtigung der Uebertragung durch Heredität oder Contagion, von Dr. Ed. Arning, Hamburg.

Exanthemata Medicinalia Externa, von T. Colcott Fox, of London.

Beitrag zur Glossopathologie, von Dr. Max Joseph, in Berlin.

Ueber die Anwendung eintrocknender Linimente (Linimenta Exsiccantia) bei der Behandlung von Hautkrankheiten, von Prof. Josef Pick, in Prag.

La Tuberculina di Koch nella Lepra, Prof. P. Ferrari. La Linfa de Koch en Dermatologia, par el Doctor Juan Aziea.

Away with Koch's Lymph, by Nicholas Senn, M.D., Ph.D.

A Plea for Public Health Work in Villages, by Henry B. Baker, M.D.

Chronic Urethritis, by L. Bolton Bangs, M.D.

Some Cutaneous Eruptions Appearing under Plaster-of-Paris Dressing, by George T. Elliot, M.D.

Addresses and Essays (Venereal and Other Diseases), by G. Frank Lydston.

Stricture of the Rectum, by Chas. B. Kelsey, M.D.

Tests for Sugar in the Urine, by Brandeth Symonds, A.M., M.D.

A Study of Sterility : Its Causes and Treatment, by Thos. W. Kay, M.D., of Scranton, Pa.

Bacteriology and Preventive Medicine, by Stephen Smith Burt, M.D.

An Analysis of the Statistics of 41,500 Cases of Epidemic Influenza, by Benjamin Lee, A.M., M.D., Ph.D.

A Note on the Probable Discovery of Snake-Bite and Cholera Cure, by the Municipal Commissioner of Baroda.

The Franklin Interrupted Current, or New System of Therapeutic Administration of Static Electricity, by Wm. James Morton, M.D.

Notes on the Therapeutic Uses of Aristol, by Daniel Lewis, M.D.

The Unrestricted Evil of Prostitution, by Andrew F. Currier, M.D.

Items.

American Dermatological Association.—The following completed programme of the fifteenth annual meeting, to be held at the Shoreham Hotel, Washington, D. C., September 22d, 23d, 24th, and 25th, 1891, has been furnished us by the Secretary :

President's address.

Report of Committee on Nomenclature, and discussion thereon.

PAPERS.—Dermatitis Hæmostatica. Dr. H. G. Klotz.

A Case of Lupus Erythematosus with Fatal Complications. Dr. W. A. Hardaway.

Report of a Case of Universal Erythema Multiforme, with colored portrait and specimen. Dr. L. A. Duhring.

An Unusual Case of Sarcoma, involving the Skin of the Arm : Amputation : Recovery. Dr. F. J. Shepherd.

Multiple Sarcomata. History of a Case Showing Modification and Amelioration of Symptoms with large Doses of Arsenic. Dr. S. Sherw

The Hypodermic Use of Hydrargyrum Formamidatum in Syphilis. Dr. R. B. Morison.

Report of Committee on Statistics.

PAPERS.—Discussion on Tuberculosis of the Skin :

Its Clinical Aspects and Relations. Dr. J. C. White.

Its Pathology. Dr. J. T. Bowen.

Its Treatment. Dr. G. H. Fox.

Thirteen Cases of Tuberculosis of the Skin, with Their Treatment. Dr. J. S. Howe.

A Case of Lichen Scrofulosorum. Dr. J. Grindon.

Notes of a Visit to the Leper Hospital at San Remo, Italy, with photographs. Dr. L. A. Duhring.

Retarded Hereditary Syphilis. Dr. R. B. Morison.

Alopecia Areata. Dr. P. A. Morrow.

A Therapeutic Note on Alopecia Areata. Dr. L. D. Bulkley.

Morphia Atrophica of Wilson. Dr. R. W. Taylor.

The Treatment of Pruritus. Dr. E. B. Bronson.

Prairie Itch. Dr. L. N. Denslow.

Diseases of the Skin associated with Derangements of the Nervous System. Dr. W. T. Corlett.

Treatment of Chronic Ringworm in an Institution for Boys. Dr. L. A. Duhring.

Epilation : Its Range of Usefulness as a Dermato-therapeutic Measure. Dr. J. Zeisler.

Notes of a Case of Acute Dermatitis Exfoliativa. Dr. J. E. Graham.

Note Relative to Pemphigus Vegetans. Dr. J. N. Hyde.

A Study of Mycosis Fungoides, with Report of a Case. Drs. H. W. Stelwagon and H. Leffingwell Hatch.

Lymphangioma Circumscriptum, with Report of a Case. Dr. M. B. Hartzell.

Remarks on Carbuncle, with Report of a Peculiar Case. Dr. H. G. Klotz.
Note on Erythema et Nævus Nuchæ. Dr. C. W. Allen.
A Case of Lichen Ruber. Dr. J. Grindon.
The Personal Equation in Dermatology. Dr. L. D. Bulkley.
Note on a New Method of Skin Grafting. Dr. P. A. Morrow.

American Association of Andrology and Syphilology.—In addition to the list of papers published in our July number, Dr. James P. Tuttle, of New York, will read a paper on "The Treatment of Urethral Stricture, and its resulting Conditions by Excessive Local Distention, and without cutting—including a brief Report of Fifty Cases."

Dr. Edward L. Keyes, of New York, will read a paper on "A Case of Excision of Stricture and Urethroplasty for Radical Cure," instead of one announced to be read on "Reflections Suggested by Some Recent Prostatectomies."

Members of the Society desiring rooms in the Shoreham Hotel, where the meetings will be held, should secure them in advance by addressing Devine & Keenan, The Shoreham, Washington, D. C.

The American Dermatological Association and the American Association of Andrology and Syphilology will conjointly give a dinner on Tuesday evening, September 22d, at The Shoreham.

Tuberculous Testicle.—Verneuil recommends the actual cautery when the period for castration has passed. Five or six points are to be plunged into the centre of the testicle, under chloroform anæsthesia. Cheesy products escape from the orifices of the wounds. It is often necessary to repeat the operation, and the patient is finally left with a rudimentary and, as the author expresses it, a *moral* testicle.

Aristol.—Dr. Lewis (*Med. Record*) finds aristol "a drug which is safe, agreeable, cleanly, and efficacious to such a degree as to render it one of the most valuable additions to our therapeutic agents which has been presented to the profession during recent years."

Excision of the Bladder.—Dr. Pawlik, Prague, reports (*The Dublin Journal of Med. Science*, June, 1891) a case of total excision of the bladder from a woman. The patient first came under his notice for persistent hæmaturia; he found a polypus, which he excised with the thermo-cautery. The following year, 1889, the patient returned, stating that the hæmaturia had recommenced. He now determined on its radical cure, and removed the whole of the bladder, suturing the ureters to the urethra. The patient made a good recovery, though when she walks the urine escapes involuntarily.

In Painful Affections of the Skin, Shoemaker advises:

Salol,	0.50 centig.
Menthol,	0.50 centig.
Carbonate of lead,	2. grams.
Vaselin,	5. grams.

To apply five or six times daily.

For Hyperidrosis, Kaposi employs:

Naphthol,	5 parts.
Glycerin,	10 parts.
Alcohol,	100 parts.

Or as a powder:

Naphthol (powdered),	2 parts.
Amylum,	100 parts.

Retinol, mixed with equal parts of oil of cade, is recommended in psoriasis.

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Original Communications.

DERMATITIS HÆMOSTATICA.[1]

BY DR. HERMANN G. KLOTZ,
New York.

HAVING suggested to the committee on nomenclature as an addition to our list of skin diseases the name of dermatitis hæmostatica, I have asked for this opportunity to state the reasons therefor. This name is not intended to signify a heretofore unknown or rare disease, but rather to assign a legitimate place to numerous cases of an affection of almost daily occurrence, particularly in hospital and dispensary practice, which, in my opinion, cannot be correctly included under the head of any disease in our present system. I mean the more or less chronic conditions of the leg in elderly people, mostly of the laboring classes, combined with varicose veins and other pathological alterations of circulation, in their various stages from simple dilatation of blood-vessels, swelling, and discoloration to hemorrhage, hard infiltration, hyperplasia, atrophy, ulceration, and cicatrization. These "sore legs," as they are generally introduced by the patients, although not considered with great favor by the dermatologist, and often generously and without grudge allowed to be absorbed by the surgical departments, nevertheless require our attention as undoubted affections of the skin. As long as there existed a separate class headed "ulcers," there was no difficulty in placing these cases, but with this class abolished, and rightly so, as I believe, they have to be classified under eczema or under dermatitis traumatica.

[1] Read before the Am. Dermatological Association in Washington, Sept. 22d, 1891.

No doubt, external injury often plays a part in the etiology of chronic ulcers of the leg, but it will produce the above-mentioned conditions only if applied to a skin previously impaired by disease, not on perfectly healthy parts. Eczema, it must be conceded, is frequently located on the leg and may itself appear in the shape of infiltrated patches very similar to those which we find surrounding chronic ulcers and scars; it must be conceded further that eczema may frequently be found upon and around previously infiltrated patches of the skin, but then it appears as a complication. To hold eczema responsible for hemorrhages, for necrosis and ulcers, for the formation of cicatrized and atrophic tissue, means setting aside all consideration of the true nature of the eczematous process. Howsoever eczema may be defined, all authors agree that it is a more or less superficial inflammation of the skin, accompanied by an exudation on the surface or into the superficial layers, tardy in affecting the cutis proper and never the subcutaneous tissue; by many it is directly characterized as a catarrh of the skin and compared to the catarrhs of the mucous membranes. Exudation in eczema never exceeds cell infiltration, leaving the structure of the skin unimpaired, and under favorable circumstances allowing of a restitution to the normal condition, except perhaps some pigmentation. Hemorrhages, formation of connective tissue, atrophy, gangrene, ulceration, and cicatrization are processes entirely foreign to eczema; and wherever they are met with, we have to look upon them as complication or as an entirely different affection. I am well aware that in some handbooks it is stated, that eczema may produce all such changes; it is but logical that if chronic ulcers and similar affections are erroneously, as I believe, included in eczema, the pathological character of the disease must be expanded sufficiently to apparently justify the consequences of the original mistake.

If, however, all the above-named conditions of the skin can be traced to a single source common to all—obstruction of circulation in a more or less extended area of the skin—and if they can easily be followed up, step by step, as the stages in the development of one continuous pathological process, due to such obstruction, it does not seem improper to include all of them in one disease, under a name which as far as possible indicates its true nature. For this purpose I propose to introduce the name of dermatitis hæmostatica as an analogue to the names of D. traumatica, venenata, calorica, and medicamentosa, already in use.

Auspitz, who has studied the effects of obstructed circulation on the skin probably more closely than any other author, in his "System der Hautkrankheiten" introduces in his first class, superficial inflammations of the skin, dermatitides catarrhales, as members of the

fourth family "Stauungscatarrhe," catarrhs due to stagnation, erythema, and superficial ulceration ("oberflächliche Hautverschwärung") ending in the chronic ulcer and in cicatrix. The introduction of this group, he distinctly states, allows us to dispense with a separate, Hebra's tenth class of ulcers of the skin. He then places the more deep-seated and important effects of obstruction of circulation in the fourth class, "Stauungs-Dermatosen," to which he abrogates the character of inflammations. Here we find under No. 1 hyperæmia from stagnation, all forms of local ischæmia, local cyanosis (livedo), and the "constant and immediate companions of venous stagnation," local hemorrhages; and under No. 2 transudations due to stagnation, œdema which may lead to hypertrophy or atrophy. As representatives of these alterations, however, he only mentions the special diseases, elephantiasis and scleroderma. Of a simple hypertrophy or atrophy he does not speak, nor of the occurrence of ulcerative or necrotic processes, which in the presence of hemorrhage and œdema, certainly cannot be considered among the impossibilities. Auspitz, therefore, leaves us to infer that an inflammation of avowedly superficial character is alone responsible for the chronic ulcer with its destruction of the skin through its entire thickness and into the subcutaneous tissue.

Kaposi, who retains Hebra's class of uclers and besides is inclined to consider the chronic ulcer of the leg as due alone to chronic eczema, nevertheless among the idiopathic dermatitides introduces D. traumatica *seu* mechanica, and distinctly states, that here he wishes to include the inflammations due to local obstruction of the circulation, "die durch Behinderung der örtlichen Blutcirculation bedingten Stauungsentzündungen." He thus acknowledges the existence of hæmostatic dermatitis, and in the general chapters on passive hyperæmia and on exudation and dermatitis pays due attention to its features.

Etiology.—The causes of local stagnation are almost invariably mechanical ones; they may be of transient nature like the pressure of tight-fitting clothes, garters, or bandages; or more permanent, like pressure from tumors, particularly from the physiologically or pathologically enlarged uterus. The most frequent cause, however, is the increased resistance to venous circulation, principally in the lower extremities resulting from continuous unfavorable position. In people who are in the habit to stand or sit with the legs hanging down, quite often while performing strong muscular exertions of the upper portions of the body, sooner or later the normal force of the circulation will cease to be sufficient for the return of the venous blood column.

Pathology.—Dilatation of the smaller and gradually of the larger veins will soon result from the increased pressure, particularly where the resistance of the blood-vessels themselves has been impaired either by structural alteration or in paralytic conditions as in elderly and marantic individuals. The capillaries will then not be sufficiently relieved of their contents and in their turn become dilated. So far the skin is only in the state of possive hyperæmia and may assume its normal condition if the cause of obstruction be removed. But if they continue, soon further alterations will take place, so gradually, however, that it is impossible to draw a line between hyperæmia and inflammation. Œdema, that is, the transudation of colorless serum from the blood-vessels in the surrounding tissue, will be the next event, followed later on by hemorrhage; that is, the escape of blood-corpuscles, either by diapedesis through the intact walls of the vessels or by rupture of the same. Then gradually all the usual stages of the inflammatory process will appear: emigration of white blood-cells and infiltration of the tissue by them, proliferation of the tissue-cells, and new formation of more or less hypertrophic connective tissue. Under favorable circumstances almost complete resolution may take place, or the skin may remain in a state of hypertrophy or by partial resorption may be reduced to an atrophic, scar-like tissue. Under unfavorable conditions the infection with parasitic elements may produce suppuration, or some portions become gangrenous, with the final establishment of ulcers and cicatrices. Renewed hemorrhages, compression of blood-vessels by the hyperplastic tissue, or occlusion from endarteritis may be the final cause of necrosis.

Symptoms.—The symptoms of obstruction of the venous circulation can easily be studied on patients, if they are examined during the early stages of their development; but at this time the patients seldom apply for treatment. The dilatation of the veins, often as varices, will first be noticed, with the formation of fine networks of smaller branches. Soon after the passive hyperæmia will manifest itself by a bluish hue of the skin, which will be the more distinct the more rapidly stagnation sets in. It will often be accompanied by œdema. On further observation between the minute branches of the veins, small red spots will be noticed on different localities. They are not sharply defined and will disappear under pressure. Later on they will retain their color under pressure either entirely or in the shape of numerous small, dark dots owing to small hemorrhages, or the small pinhead-sized specks will be observed in the periphery of the larger spots. They may disappear again, leaving brown pigmented spots. The red patches gradually extend, become confluent, and show increased infiltration and loss of elasticity. Later on larger patches of a dark

blue tint are formed, sometimes extending around the whole circumference of the extremity; at the same time the skin becomes more and more immovable, hard, sometimes smooth and shiny, sometimes covered with hard scales or crusts, particularly where suppuration has formed a complication. In this condition the leg may often remain for a long time without undergoing any new changes except gradual peripheral extension of the patches. But at any time, either under the influence of external injury, or after an extraordinary exertion or without any apparent cause, with or without the appearance of larger hemorrhages, necrosis and ulceration may take place. In other cases, perhaps where the epidermal cover is particularly firm and tense, or where the subcutaneous fat-tissue is but poorly developed, the skin may assume a more atrophic condition. Then we find the skin of a light brown, mottled or uniform color, hard and dry, tensely adherent to the underlying tissue, particularly over the tibia. In the circumference these patches exhibit a more reddish tint and contain numerous fine, red specks. I believe that a case presented by Dr. Cutler to the New York Dermatological Society and reported in the January number of this JOURNAL, must be considered a case of atrophic dermatitis hæmostatica. It was really the consideration of this case which induced me to study this question.

As has been stated before, eczema may frequently locate on portions of the skin affected by dermatitis, and then the features of the complicating eczema may predominate over those of the original disease.

The subjective symptoms in the early stages of dermatitis hæmostatica are very slight; particularly itching is entirely absent or but very slight for a long period; a feeling of heaviness or stiffness is very often the only inconvenience for the patients. This is the reason that such cases are but rarely seen in the early stages and go about for years without any treatment. It is only when by some over-exertion or by some injury the dermatitis begins to assume a more acute character or ulceration becomes imminent, or has already taken place, that pain is experienced, but then, as a rule, so intense and continuous that the patient has to give up work. The suffering resulting from chronic ulcer need not be considered here any further.

The distinguishing features of dermatitis, particularly from eczema, are the early symptoms: dilatation of the veins, livedo and œdema, the early occurrence of minute hemorrhages, the appearance of small, disseminated red patches and their confluence, and finally the participation of the skin in all its portions, ulceration, and cicatrization.

42 EAST 22D STREET.

ON SYPHILIS OF THE EXTERNAL EAR.*

BY ADOLPH RUPP, M.D.,
New York.

I.

BY the terms external ear are meant the auricle, the external auditory canal, the exterior aspect of the membrana tympani or drum-head, and the visible part of the mastoid region; that is to say, those parts of the auditory apparatus covered by skin tissues.

II.

Syphilis manifesting itself on the external ear usually but not always does so in connection with manifestations of the disease elsewhere on or in the body. All the known eruptive lesions of syphilis have been observed on the external ear, but their occurrence is comparatively very rare. The primary, secondary, and tertiary forms have been seen on the various parts of the external ear, not by any one observer, but by them collectively, otologists and syphilographers.

Regarding the frequency with which syphilis is found on the various parts of the external ear, much depends on the point of view respecting the conclusions arrived at and expressed. Much looseness in the use of qualifying numerals has been indulged in by a number of much read and much quoted writers on this subject.

The literary view and the point of view of personal or individual experience do not tally very well. Thus Kipp[1] writes, "Syphilitic eruptions are not very rarely observed on the auricle"; and again, further on, "the external auditory canal is not very rarely the seat of broad condylomata and of ulcers." His personal experience as an otologist has been and is a large and fruitful one, but in all that ample experience he saw condylomata affecting the external ear only twice in sixteen thousand ear patients. Acton[2] says, "Syphilitic disease of the ear is rare, and close observers have not written upon it"; and our own (Robt. W.) Taylor[3] remarks "that cases of syphilitic disease of the ear, or those recognized as such, are rare."

The following figures, taken from the books of the New York Eye and Ear Infirmary, though not beyond criticism, prove none the less that syphilis of the ear is of rare occurrence. Of twenty-eight thousand one hundred and eighty patients examined in the aural department in the course of twelve years, only twenty-one are reported as syphilitic affections of the ear, and thus:

* Read at the March (1891) meeting of the Society of the Alumni of Charity Hospital.

External ear, ...	10 times.
Middle "	10 "
Inner "	1 time.

And so, only once in about twenty-eight-hundred ear patients was syphilis of the external ear observed.

In my own practice at the same infirmary I have seen five cases of syphilis affecting the external ear (in every one of which syphilis was otherwise evident), in over four thousand ear patients examined in the course of about eight years. In private practice—one of a mixed character, general and special—I have in the course of ten years seen the external ear affected with syphilitic lesions only twice.

Buck [4] reports thirty cases of syphilis of the ear or hearing apparatus in three thousand nine hundred and seventy-six ear patients.

Deprès,[5] in the course of six years, examined twelve hundred syphilitics, and found lesions on the external ear only six times.

And Ravogli,[6] in one hundred and forty-four syphilitics, found the external auditory canal only once affected, but the middle ear fifteen times implicated.

III.

Chancres.

By searching the medical literature of the civilized world, one dozen or more cases of chancre located on the posterior aspect of the auricle, at the base of the tragus, on the lobule of the auricle, on the mastoid region, and once within the external auditory canal can be found and wondered at. The mode of origin here is attributed to kissing, bites, syphilitic towels, and other problematic causes.[7]

Roseola.

This eruption occurs on and around the external ear at the time it is seen on other parts of the body, according to Gruber's [8] observation. Its unimportance may account for its not being mentioned by other writers, otological and syphilological.

Maculæ.

Kaposi, [9] in his recent treatise on Syphilis, does not mention the occurrence of this lesion on the ear. Of course Gruber has seen it.

I noticed it once—during the fifth month after infection. The eruption was very marked all over the body, face, and forehead, and I might not have noticed it on the auricles and outer portion of the external auditory canals and mastoid regions if it had not been particularly necessary to examine the ears on account of a slight though distinct amount of deafness that was complained of. This variety, says

Taylor,[10] "is most frequent in those portions supported by cartilage, as the fossa navicularis and concha." Urbantschitsch mentions its occurrence in the external auditory canal.

Papules.

Taylor, agreeing more or less with Gruber, avers that syphilitic papules are met with in the posterior auricular angle and upon the lobule of the ear. Taylor and Kaposi have not found them in the external auditory canal; but Gruber claims a place for them at the inner end of the canal, where they undergo retrogressive epithelial changes. Gruber has seen these papules on the membrana tympani become pustular and ulcerative, and finally give rise to its perforation (membrana tympani). In all this, Gruber has seen more than any one or all observers prior to 1870, and what no single observer since then has been able to report.

Kaposi[11] cites E. Lange as having once seen a formation resembling a papule on an opaque and inflamed drum-head. This case, says Kipp,[12] was a woman with early symptoms of syphilis; the papule was located in the upper segment of the drum-head.

Acton[13] has it that these papules may become so abundant at the meatic orifice as to close it, and of course thus give rise to more or less deafness.

Condylomata.

It is written, "the external auditory canal is not very rarely the seat of broad condylomata";[14] but experience tells the story in numbers as follows: In over nine thousand ear patients, Knapp (Prof. Hermann) saw condylomata in the external auditory canal but once; Kipp[15] saw only two cases of condylomata of the ear in sixteen thousand ear patients; Buck noticed two cases in about four thousand ear patients; and I saw the lesion only three times in over four thousand ear cases, examined in the course of eight years. Deprès, in the course of six years, examined twelve hundred syphilitics, and found that, though nine hundred and eighty of them had condylomata in various regions, only six had this lesion on the external ear. And Ravogli examined one hundred and forty-four syphilitics, seventy-seven of whom had condylomata, but none of them on the ear.

Stöhr, in three years' time at the general hospital at Würzburg, found fourteen cases of condylomata affecting the external ear.

This lesion is most frequently found on one ear. Deprès found them on both ears only once in six cases. I found both ears affected twice in three cases. The majority of Stöhr's cases were one-sided.

This lesion on the ear is oftener seen in females than males. Eleven of Stöhr's cases were females. Two of my three cases were females.

As to the location of this lesion in the external auditory canal, authors differ in what they say, the difference being probably due to individual experience. According to v. Troeltsch, they are aptest to be found at or near the meatic orifice, which was the site of this lesion in two of my cases. Urbantschitsch locates them at the inner end of the canal. Deprès found the lesion here only once in five cases, and then it extended over on the drum-head. Pomeroy has seen a case similar to this one of Deprès. Four times Deprès found the lesion in the lower posterior wall of the canal, and this was the site in the other of my three cases. Stöhr found them usually located about the middle portion of the canal, and only once at the meatic orifice.

Taylor says that at the meatic orifice the condylomata are isolated, but multiple at the inner end of the canal; Schwabach [16] saw a papular condyloma that involved the entire canal. In two of my cases (the one a young man, the other a young woman and a prostitute) the lesion was multiple and occluded the meatic orifice.

This lesion has also been seen on the lobule of the ear, on the mastoid region, and along the posterior auricular angle. Politzer has twice seen sharply defined, whitish plaques on the membrana tympani.

This lesion in the canal is usually moist, and gives rise to a discharge from the ear. It is supposed by some that otorrhœa precedes the development of the condylomata. This, though probable in many of the cases, is not always so. Condylomata are at times dry. One of my three cases was such. The lesion affected only one ear. This was an elderly woman who did not know that she had syphilis. She had nasal and throat evidences of the disease. She attributed all her troubles to catarrh. Her deafness was not due to the condyloma in her right canal—it did not obliterate the lumen of the canal. And it was only the necessary aural inspection that brought this condyloma to notice. Acton [17] says, "I have seen these condylomata occur in cases where there was no other skin affection. . . ." In my case the lesions mentioned were the only discoverable ones.

Gummata.

Gruber [18] finds that, though gummata occur in the canal and on the auricle, they are found oftenest on the mastoid process, where they at times attain a large size. These intumescences, he says, are soft and elastic, may or may not be circumscribed or diffuse into healthy surroundings, and sometimes simulate the characteristics of periosteal inflammation. When they ulcerate, the borders of the ulcer become infiltrated and callous, and the whole lesion assumes an indolent character.

Hessler has seen a gumma in the auricle end in partial necrosis

of the cartilage—and this occurred in a case when there were no other specific evidences plain. In a young man at the infirmary I found a gumma of the lobule of the auricle. This patient had denied syphilis, but the evidences of this disease had been observed in the throat and by stains on the arms and face. In order to demonstrate the nature of the swelling in the lobule, I cut into it.* There was no pus, no steatomatous matter, nor fibrous surface, but the reddish, fatty, glistening appearance. There was no ear-ring irritation in this case.

Kipp [19] quotes a most interesting and unique case reported by Barratoux: a woman had five small gummata on the cheek in front of the ear, a sixth on the mastoid process, three on the concha and outer portion of the external auditory canal, a small oval, faintly opalescent intumescence on the lower posterior portion of the drum-head, besides a small round ulcer in front of the malleus handle. When seen a few days later, the little "tumor" on the drum-head was beginning to ulcerate, and the ulcer to heal.

Ulcers.

Frank, over sixty years ago, mentioned the occurrence of ulcers of a specific well-known character in the external auditory canal. Gruber, writing about twenty years ago, described circumscribed specific inflammations and pustulations which heal readily in other regions, but which in the external auditory canal become obstinate or indolent and end in ulcers that have a dirty-grayish, diphtheritic deposit. Such ulcers, he claimed, demand energetic local as well as specific treatment, in order to spare the patient much suffering and prevent the increase of this ulcerative process. Again, he had also seen cases in which the character of the ulcers was at first benign, and for some reason or other the ulcers assumed a rapidly retrogressive character, the inflammatory phenomena and ulceration increasing even to the destruction of deeper parts and the membrana tympani. Schwartze has seen ulcers in one ear only, and in both canals simultaneously. They occurred in connection with tympanal disease, also when the middle ear was free from disease. These ulcers were usually rounded in form, had elevated edges, and gave rise to more or less narrowing of the canals.

Kirchner [20] saw a syphilitic ulcer involving the larger part of the posterior half of the drum-head, which, though the cause of much pain (otalgia), healed rapidly, and did not give rise to perforation of the drum-head.

Buck [21] has seen a syphilitic ulcer on the lower wall of the outer half of the external auditory canal and reaching out on the auricle. In another case he saw an ulcer the size of a three-cent piece in the

* This was done before a class of students.

fossa conchæ. This ulcer was covered with pus under a crust, and its floor had a papillary appearance. In a third case the tragus and outer portion of the meatus was swollen, especially superiorly; and deep ulceration of the auricle at the commencement of the helix above the meatic orifice was found. This ulcer extended down to the cartilage, and measured half an inch in diameter. In all of Buck's cases syphilis was evident in the nose, throat, and otherwise.

Burnett [22] describes a tubercular syphilide, which he saw in Duhring's practice, that began on the posterior aspect of the auricle, involving in time its larger portion, and, after spreading over in the mastoid region, began to ulcerate. Sexton [23] has described cases where the process began on the anterior aspect of the auricle, and among them one in which "the superior portion of both auricles was the seat of eroding ulcers covered in part with thick, dark crusts emitting a disagreeable odor," the ulcerative process, as far as it went, destroyed the cartilage as well as dermal tissues.

Hinton, Politzer, and others besides have mentioned or described syphilitic ulcerations on the external ear.

Exostoses.

Gruber claims, with much positiveness, that exostoses in the external auditory canal are at times due to syphilitic influences. Nobody, except Knapp perhaps, has ever experienced any reason for agreeing with him. Kaposi and Taylor mention them by quoting Gruber. Despite the denials from von Troeltsch, Miot and Barratoux, Kipp, Pomeroy, and others, Gruber [24] reaffirms their occurrence, as one of the phenomena of syphilis, as being beyond a doubt and irrefutable.

Those cases of exostoses of the external auditory canal that have come under my observation did not allow a syphilitic explanation which is the common experience. Gruber's observations, though expressed in general terms, implied an extraordinary numerical experience, and everything else connected with the subject, as seen by him and described by him, was so pat and nice and beyond every one else's experience that scepticism rather than assent has been roused. However, Gruber claimed nothing that was or is impossible.

These bony growths are found at the inner end of the external auditory canal near the membrana tympani. Their base is broad. They may occur singly, or two or three may jut their apices into the lumen of the canal, blocking it more or less; and thus sound will be hindered more or less from reaching the membrana tympani and perceptive hearing apparatus, and more or less deafness result. Their commonest seat is the posterior wall, and the least frequent the anterior wall. They develop slowly, and do not give rise to pain.

Miscellaneous Affections.

Lacharrière describes a diffuse otitis externa of a specific nature; the skin is red, swollen, cracked, and discharges an offensive matter. McBride claims to have seen a similar specific condition, but the discharge was not malodorous. Lacharrière says the trouble is common during the secondary stage. I have not seen this affection, and McBride[25] and Lacharrière are the only authors who mention it.

In the course of the discussion of this paper, Dr. Robert W. Taylor called attention to the following troubles, which are important in themselves, but very much more so because they might be mistaken for ordinary eczemas to the distress of the patient and disgrace of the physician. Professor Taylor* has been so kind as to write out some of his remarks, which here follow:

"There is a tubercular syphilide found on the ears which may at first be localized in spots or patches (papules or tubercles), but its lesions do not, as a rule, become sharply limited, and show a tendency to diffuse themselves over the surface. The whole thickness of the skin is involved, and these patches are reddish or brownish in color. In some instances they are scaly and look like lupus exfoliativus, and in others when subjected to irritation or in uncleanly persons become inflamed and exulcerated, and in this condition a sero-purulent exudation occurs on their surfaces, which may dry into crusts. In this condition I have seen this syphilide present a marked resemblance to eczema impetiginosum. This lesion runs a chronic course and usually ends in atrophy or cicatrization. . . . Dry papular syphilides are also prone to appear on the ears, and then diffuse themselves circumferentially and produce reddish-brownish patches which look like seborrhœic eczema and even psoriasis. This lesion occurs within the first year of infection. The first form may appear precociously in the first year, but by far more frequently in the second year and later."

These lesions may appear on other parts of the body at the same time, and only on the ear when the disease is in all other respects dormant or altogether absent so far as other evidences are concerned. Dr. Taylor is, so far as I know, the first to have recognized and described these forms of lesions—at least, so far as the ear is concerned; and considering that about three per cent of all aural diseases are eczemas, Dr. Taylor's observations are nothing less than very important both to the otologist and dermatologist, from a diagnostic point of view, and therefore therapeutically.

* I wrote out what I remembered of his remarks and sent them to Dr. Taylor, asking him to correct me if I did him injustice in any way. With characteristic good-will Dr. Taylor wrote out for me what is quoted.

Kipp mentions a case that he supposes was similar to those described by Lacharrière and McBride, but which seems rather, judging by Kipp's description, to have been a case of specific ostitis and periostitis. In this case the osseous part of the canal was red and swollen, there was a good deal of pain, but there was no exudation from the canal. After long suffering, the pain eventually subsided while the patient was taking iodide of potassium. All this occurred years after infection; and, besides the clinical symptoms already narrated, there were "non-purulent inflammation of the middle ear" and caries of the superior maxillary and palate bones of the same side. The case was not one of disease of the external ear only, but I have quoted it because the symptoms of the external canal were marked, and had received local treatment in the way of repeated incisions, which failed to give the relief that usually follows in ordinary cases of periostitis. Complete deafness was the result in this case after the bone disease was cured.

I had a similar case transferred to my clinic by Professor Lefferts five years ago. In this case there was acute middle-ear inflammation, besides periostitis of the canals and mastoid regions, mild on the left side, and severe on the right side. There was a discharge from the right canal, through a fistulous opening at the junction of the cartilaginous and bony portions, and this opening was surrounded by granulations bathed in pus. There was besides a good deal of swelling over the entire right mastoid region, but it was most marked at the apex of the mastoid, where there was also distinct fluctuation. The inflammation and swelling extended down the neck for a short distance, especially along the sterno-cleido-mastoid muscle. In the presence of Professor Lefferts I made a deep incision, beginning a little below the mastoid apex and extending it up to a level with the external canal—cutting down on the bone. Much blood, but little pus came away. Only little relief from intense pain followed. The specific treatment started by Dr. Lefferts was continued. This case began as one of nose and throat syphilis, and is referred to because there were —besides tympanal disease—a swollen and inflamed condition of both canals, a discharge from the right canal through a fistulous opening in the lower posterior canal wall, and because granulations almost filled up the lumen of the canal (on the one side).

Schwartze has had something to say on granulations found in the canals of syphilitics. I have not been able to consult his article, and must quote Roosa:[26] "While it is true, as Schwartze intimates, that it is sometimes difficult to decide whether a given case of granulations in the auditory canal depends upon a syphilitic dyscrasia or not, since the anatomical constitution of the tumors is the same whether syphilitic or not, yet this is usually not the case."

IV.

General and Concluding Remarks.

1. It has been shown that the various dermal lesions of syphilis may manifest themselves on the external ear.

2. These lesions may occur early in the history of the disease, and they may make their appearance at a late stage; and, furthermore, they may be, and frequently and usually are, associated with specific lesions found elsewhere in the body; *but syphilis on the external ear may occur when it is not to be found elsewhere.*

3. These lesions may be found unilaterally, or on both ears simultaneously.

4. Aside from the cosmetic shortcomings these lesions may give rise to, they may, when affecting the external auditory canal, give rise to more or less deafness coming on more or less suddenly. And when this is the case the patient should be referred to the otologist—first, it should be borne in mind that all these external lesions may appear in connection with serious middle-ear disease or even labyrinthic trouble; and secondly, because only the trained eye and hand of the otologist should be allowed to remedy the difficulties of audition when they occur in the external auditory canal, for it is not at a glance that all that may take place in this little canal can be distinguished and defined.

5. The otalgia that occurs in these cases is, according to most authors, more persistent than ordinary non-specific otalgias from whatever cause. And when otalgias occur the trained eye of the otologist should be made use of, for in ear troubles the most willing and gentle hand is rough and cruel unless guided by a trained and knowing eye.

6. Discharges from the ear occurring in the course of syphilitic disease ought not to be looked upon as of little or no moment, although cases do perhaps occur in which the otorrhœa as well as the otalgia disappears with the active symptoms of the disease. Stöhr has seen condylomata relapse, and it will be recollected that discharges and uncleanliness favor the development of condylomata—though these give rise to discharges when in the canal; therefore, in this commonest event of rare contingencies, to rely exclusively on general treatment would probably result in disappointment for the doctor, and possibly disastrously for the patient's hearing and social and individual comfort. Besides, as has been seen by cases cited, ulcers in the canal or on the drum-head, granulations and condylomata, etc., near the drum-head, and bone disease, or only other simple dermal lesions may give

rise to otorrhœa or discharges from the ear, which conditions call for local treatment other than that of simply ordering cleanliness by "syringing the ear from one to a dozen times a day." And, certainly, whatever local treatment may be necessary ought to be applied by one who can diagnosticate the nature and the site of the lesion. Blind or even empirical treatment is not justifiable when an enlightened diagnosis can accomplish better things. Otorrhœa may antedate the syphilitic phenomena; and, if so, so much greater the necessity for not expecting good from letting things take their wonted course. A running or discharging ear is always a diseased ear, and there is neither art nor science in letting things alone.

7. On the whole, syphilitic disease of the external ear is rare. Almost everything in the way of syphilis occurs here, but it is far from being true that any one man, however ample his clinical experience is or may have been, has seen all the lesions in the various localities of the external ear. Here, as in all other affairs, all men have seen all things.

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SOME REMARKS UPON THE DIAGNOSIS OF GONORRHŒA IN THE MALE, NO. 2.[1]

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The Value of Urethroscopy.

THE value of the urethroscope in the diagnosis and treatment of urethritis has been the subject of frequent discussion of late by those interested in genito-urinary surgery. There seems to be as yet a very decided difference of opinion as to some of the questions involved, and in the articles upon the subject which have appeared the most opposite views may be found. Those who take the extreme conservative view reserve the urethroscope for cases of chronic urethritis that have resisted treatment. Others go to the opposite extreme and advise its use in every case as soon as the more acute symptoms have subsided. On the one hand it is asserted that the information gained does not compensate for the irritation which in most cases is caused by the urethroscope. On the other hand it is claimed that urethroscopy is the only rational method of diagnosis and treatment in chronic urethritis. The difference and diversity of opinion upon this and upon other questions involved is confusing to those who have had little or no experience in urethroscopy. It has probably deterred many from testing practically a method which requires the expenditure of so much time, and the value of which is apparently so uncertain. Whatever the cause may be, the fact remains that the use of the urethroscope is by no means general either in the diagnosis or in the treatment of urethritis.

In considering the value of urethroscopy, it is necessary to distinguish between its use in diagnosis and its use in treatment. Some of the confusion and misunderstanding which now exist has been due to a failure to recognize the distinction.

In the following remarks I shall speak of the urethroscope as an aid in diagnosis only, and of its use in this respect.

In the first place it is necessary to say a word in regard to the choice of instruments. At the conclusion of a former article in the August number of this JOURNAL I called attention to some of the new improvements which have been made in urethroscopic instruments. It was there stated that I prefer a combination of Klotz's urethroscope with the electric light and reflector designed by Dr. W. K. Otis.[2] The

[1] Continued from the August issue of this JOURNAL.

[2] See Fig. 1, Part I., JOUR. OF CUT. AND GENITO-URIN. DISEASES, Aug., 1891.

latter I believe to be the most valuable contribution which has been made to urethroscopy since its reintroduction into genito-urinary practice. It gives me great pleasure to express here my personal obligation to Dr. Otis. The combination of these instruments gives a simple and easily manipulated urethroscope which is better adapted for general use that either Leiter's instrument or the speculum of Dr. F. T. Brown. The latter is useful in the anterior part of the urethra only. While it is in some cases a valuable instrument, it requires longer practice and more skill and dexterity to employ it to advantage than the urethroscope does. One of the principal advantages of the combined instrument is that with very little practice any one who is reasonably skilful with urethral instruments can use it. During the past six months I have used it in the majority of cases examined. In estimating the value of urethroscopy in diagnosis, the conclusions reached are founded principally upon the results obtained during this time. Although I have used the urethroscope for several years in the diagnosis of cases which were obstinate, it is only within the past year that I have resorted to it extensively as an ordinary method of diagnosis.

By the methods of diagnosis described in the first part of these remarks we can determine only partially the nature of the morbid conditions present in any case of urethritis. This fact, together with the imperfect knowledge which we have of the anatomy and pathology of the disease, renders of value any method which will give more complete information without causing too much irritation in the urethra.

Two questions here present themselves: 1. What information does the method of diagnosis by the urethroscope afford? 2. How much irritaton does it produce?

1. A thorough diagnosis cannot be made by urethroscopy. The urethroscope is an aid to diagnosis, and is used in addition to other methods of which I have spoken. It does not take their place. It gives us information principally as to the appearance of the surface of the mucous membrane of the urethra. By other methods of diagnosis already described we gain information as to the nature of the disease (*i.e.*, whether it is gonorrhœa or not), as to its intensity, and the portion of the urethra involved. We are able to determine also more or less accurately the extent of the inflammation. The urethroscope informs us more exactly with respect to these last two points. We discover also the appearance of the surface changes; viz., whether the mucous membrane is granular, ulcerated, or simply congested. We learn also the condition of the orifices of the urethral follicles. We can in many cases ascertain the amount of infiltration present in the walls of the urethra, especially when it is confined to the mucous

membrane. When there are several areas of inflammation in a urethra representing different stages of the disease, the urethroscope is of special value, as without it the variations in appearance cannot be detected. In measuring the urethral calibre the urethroscope is of very little value; but when the presence of stricture has been determined by other methods, if the calibre be large enough to admit of the introduction of a tube, important information can be obtained as to the condition of the urethra at and near the point of constriction.

2. The other question, as to the amount of irritation caused by the urethroscope, cannot be answered categorically. The extreme views taken of this question are misleading. The introduction of any instrument into the urethra is objectionable *per se*, because it is likely to be irritating, but the degree of this irritation depends upon the condition of the urethra at the time the instrument is introduced, upon the character of the instrument, upon the skill of the operator, and in many cases upon the peculiar sensibility of the individual into whose urethra the instrument is passed. The introduction of the urethroscope into the urethra before the acute stage of a urethritis has subsided will undoubtedly do harm. So also will the unskilful management of the tube during an examination be likely to increase the trouble, even in a urethra which is the seat of an old and chronic inflammation.

Any one with sufficient dexterity to justify him in using urethral instruments can with proper care, however, make a urethroscopic examination without unduly exciting irritation, provided the condition of the urethra calls for the introduction of any instrument. As the tube of the urethroscope is straight, its passage beyond the bulbous portion of the urethra is more likely to cause harm in unskilful hands than a curved instrument would. But the ability to pass a straight instrument is easily acquired.

A badly made tube or one which has an ill-fitting obturator will of course be likely to increase a urethritis, but the use of such an instrument need seldom be taken into consideration.

From what has been said it will be evident that the fear of increasing the disease need not interfere with the use of the urethroscope for purposes of diagnosis, provided the examination be carefully conducted and the case be one requiring the introduction of any instrument. It will also be apparent it is of the greatest service to be able to see the character of the changes caused by chronic urethritis. And yet the beginner in urethroscopy is likely to be disappointed at first. Just as with the ophthalmoscope the surgeon must have had practice before he is able to interpret what the instrument reveals, so it is with the urethroscope. In order to appreciate at its full value the knowl-

edge obtained by its use, the examiner must be familiar, not only with the appearance of the healthy urethra, but also with the variety of the morbid changes produced by inflammation of the urethra. This is to be obtained only by careful practice. There are comparatively few surgeons who have the opportunity, even if they are willing to devote the time necessary to gain this experience, and it is therefore probable that the practice of urethroscopy will never become general. To any one whose practice is principally in genito-urinary surgery the urethroscope must, I think, become a necessity, and a surgeon who is frequently called upon to treat urethritis owes it to his patients to take advantage of this source of information which is of such practical value.

My own experience with the urethroscope was at first very unsatisfactory on account of the imperfection of the instruments. But since I have had the urethroscope recommended above, the value of the information obtained by it has been steadily increasing. I am speaking now chiefly of its value in diagnosis. Its use in treatment is very limited, because in most cases it would have to be introduced frequently, and this would certainly be irritating to the urethra. When it is desirable to make a very strong local application to any portion of the urethra, or to make applications of different strengths at various points in the canal, the urethroscope is invaluable, but I believe there is some danger in using it too frequently in the treatment of urethritis.

There are one or two practical suggestions as to the use of the urethroscope in diagnosis. As intimated above, the urethroscope should never be used during the acute stage of urethritis, nor do I believe that it is proper to employ it until the inflammation has been localized. In cases where a diagnosis cannot be made without the use of an instrument, the urethroscope may be used with safety and advantage. Where the meatus is abnormally small the urethroscope is useless, for unless a tube of at least the size 26 F. can be introduced very little information can be obtained. It is better under such circumstances either to divide the meatus or to attempt the treatment of the case upon the diagnosis made by the ordinary methods. In cases in which there has been a recent urethro-cystitis or an epididymitis, the urethroscope should be used with great caution in the posterior urethra. The urethroscope should always be introduced into the membranous portion of the urethra, even when the disease is confined to the anterior portion. Unless this precaution is taken, that portion of the bulb nearest the isthmus cannot be seen, and this is one of the most frequently diseased parts of the canal.

Without giving a detailed description of the appearance of the different parts of the healthy urethra, it may be of advantage to call

attention briefly to the more important points which should be noted in making a urethroscopic examination.

The different parts of the normal urethra are recognized through the urethroscope by the shape of the central figure, by the length of the funnel formed by the mucous membrane with the open end of the tube, and by the color.

Thus the color of the mucous membrane in the part of the prostatic portion of the urethra nearest the bladder is a dark red, but becomes paler near the membranous portion. The central figure is at first circular, but becomes concentric, the concavity of the curve being turned toward the floor of the urethra or to the left side. The distinctive shape of the central figure is caused by the protrusion of the *veru montanum*, the latter occupying about three-fourths of the entire field. The mucous membrane of the membranous portion of the urethra is a paler red than that of the prostatic portion, the central figure is punctate, and the funnel is quite shallow.

The color of the bulbous portion of the urethra is subject to great variations. It may be of almost any shade of red, but is usually of a pale flesh-color. The color of the penile portion is also subject to variations; it is usually paler than the bulb and has a more fleshlike tint. These peculiarities are the same in the inflamed as in the healthy urethra. The principal changes produced by urethritis which are revealed by the urethroscope are: (1) Changes in shape and length of the funnel due to infiltration; (2) lack of lustre, and cloudiness of the mucous membrane, as the result of destruction of epithelium; (3) changes of color, the mucous membrane being either a bright scarlet as the result of active congestion or purplish from passive hyperæmia, the superficial vessels are also often very prominent; (4) the presence of granulations upon the surface; and (5) erosions and true ulcerations. The latter is a comparatively rare condition. These changes are often slight and cannot be distinguished except by a practised eye. There may be changes in color as the result of temporary congestion.

The importance of being familiar with the variations in the color found in the healthy urethra cannot be overestimated; for the normal appearance is not always the same. The redness of the healthy prostatic portion would be taken as a sign of congestion in the penile portion of the urethra. It should be remembered in making a visual examination of the urethra that, after a prolonged inflammation, congested areas often remain, which should not be regarded as constituting disease.

I have found the urethroscope of value in regulating treatment as well as in determining the character of morbid changes produced by

urethritis. The effect of any local application may be seen and its strength increased or diminished accordingly.

Enough has been said, I hope, to show that, properly used, the urethroscope is a valuable aid to our methods of diagnosis. All the methods mentioned are necessary, and have their proper place, but until we have a more perfect knowledge of the pathology and minute anatomy of urethritis it will not be possible to make a completely accurate diagnosis.

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THE TREATMENT OF ALOPECIA AREATA—WITH CASES.[1]

By PRINCE A. MORROW, M.D.

WHILE the pathogenesis of alopecia areata is obscure and still the subject of controversy, the widely divergent views as to the nature of the disease do not lead, as would naturally be assumed, to an equally radical difference in the treatment employed for its cure. Practically we find methods of treatment are not materially modified by etiological conceptions. Agents which determine a more or less intense irritation of the affected areas constitute the basis of all special therapeutic treatment—the choice of the agent depending upon the personal predilections of the physician. Those who hold to the tropho-neurotic theory of the disease employ topics which are stimulating and at the same time often parasiticidic, while those who believe in its microbian nature recommend agents which possess both parasiticidic and irritant properties. The adherents of both theories admit that the disease is, as a rule, essentially self-limited, with a tendency to spontaneous recovery, and that many cases get well without any treatment whatever.

The object of this paper is not simply to pass in review the therapeutics of alopecia areata, but rather to refer to certain points of interest in connection with cases which have recently come under my observation and indicate the methods of treatment which have proved successful. One of these cases was peculiarly interesting from its generalization, its long continuance, and the development of certain curious features in its clinical course which may serve as an apology for describing it somewhat in detail. To avoid useless repetition, the details of the general plan of treatment followed, with slight modifications, in all the cases, will be given separately.

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[1] Read before the American Dermatological Association at the Congress of American Physicians and Surgeons in Washington, Sept. 22d, 1891.

CASE I.—G. H. B., æt. 26, dark-complexioned, slightly built man, came under my observation in September, 1889. His family history was good and he had always enjoyed excellent health with the exception of a severe attack of acute articular rheumatism. In February, 1889, he first observed a spot of baldness over the chin, which gradually spread over the right cheek. A month or two later a bald spot appeared over left temporal region, above and behind the ear, soon succeeded by the development of similar patches upon different portions of the hairy scalp.

During the winter of 1889–90 the alopecic process gradually extended over the entire face, sweeping away in succession the mustache, the eyebrows, and the eyelashes; coincidently the hairy scalp became entirely denuded, except a few hairs showing in scattered tufts over the occipital region. The morbid process also extended to the surface of the body, first sweeping away the hair of the pubes.

In April, 1890, the patient was presented before the New York Dermatological Society as an example of the parasitic form of alopecia areata, the evidence being based upon the clinical course and mode of extension of the disease. I stated "it was fair to presume that the disease was parasitic, as the hair of the pubes had been implicated, while the hair of the intervening regions, the chest and the axillæ, was unaffected. There were multitudinous chances of direct transfer of the parasite from the head as a centre of infection to the genital region in handling the parts."

Conclusive proof of the contagiousness of the disease was furnished two months later by the patient bringing me his sister, who had contracted the affection presumably by wearing his cap.

From the pubes the alopecia extended upward to the axillæ and downward upon the limbs until it became universal; not a single pigmented hair could be detected upon any portion of the body.

This condition of universal alopecia persisted for several months, the surface of the scalp remained smooth, polished, and entirely destitute of any vestige of hairy growth. The hair follicles could not be detected by the unaided eye; under a magnifying glass they could be distinguished as minute punctiform depressions. This disappearance of the follicles was, however, only apparent. Under the influence of a strong stimulant they could be made to project and thus be brought into prominence. In the fall of 1890 there was discernible upon the vertex a growth of fine lanugo-like hairs, perfectly white, and so loosely rooted that the slightest traction or friction would cause them to come out. In the next few months there was a series of crops, improvement being indicated by a greater abundance of each successive crop and the appearance here and there of coarser pigmented hairs.

In the spring of 1891 there could be noted quite an abundant growth of stronger pigmented hairs on the vertex, with entire absence of any semblance of growth upon the sides and occiput.

The peculiarity of this growth consisted in its being confined to the vertex, extending in a circle from the frontal margin of the scalp to the summit, and limited inferiorly to the middle of the parietal region

on each side, while the inferior parietal, the temporal, and the occipital regions were entirely bald—exactly reversing the picture ordinarily seen in alopecia senilis or prematura. This anomalous condition continued for some months.

In June last (1891) the patient's general health appeared to be much impaired. For several years he had been living a sedentary life, closely occupied indoors from morning until night. He was ordered to live in the country, take as much active outdoor exercise as possible, dispense with his wig and expose his head freely to the air and sunlight. Under the influence of these hygienic conditions his general health was much improved. A growth of hair began to appear on the temporal and occipital regions and before the end of the summer there was an abundant growth over the entire scalp. Coincident with this regional improvement the eyebrows and eyelashes began to sprout forth and the beard and mustaches also took on an active growth. At the same time there was a regeneration of the hairs on the general surface of the body.

In connection with the rapid improvement noticeable during the past summer, I may refer to one or two circumstances which may have been purely incidental, but which I am inclined to believe exercised an important influence upon the renewed growth of the hair.

In June last the patient suffered from a severe attack of measles, the immediate effect of which was the complete loss of the existing hair upon the vertex, but which was speedily followed by a growth much more abundant and vigorous than before in this region, and also by signs of renewed activity on the part of the follicular structures of the temporal and occipital regions, as well as those of the eyebrows and eyelids.

What influence this intercurrent attack of measles may have had in energizing the hair's growth or the rationale of such action cannot be clearly explained. We know that the pathological changes in measles are distinctly grouped about the blood-vessels and follicular structures of the skin, and it is possible that the congestive stimulus thus exerted may have awakened into activity the long dormant trophic influence which presides over the pilary structures.

The other circumstance was this: The patient had interpreted rather too liberally my injunction to expose his scalp freely to the sun. On playing a tennis match bareheaded during a hot summer afternoon the skin of the face and scalp was severely blistered. This seemed to give a marked impetus to the growth of the hair on the exposed surfaces. Whether the sun's rays were more efficient than a chemical irritant is a matter of conjecture, but certainly I have never observed such a marked effect from an ordinary blister.

Before dismissing this case I may be pardoned for referring to one or two other phenomena which impressed me as being worthy of note. One feature which interested me was the prolonged continuance of hairs in their sheaths without undergoing any change whatever. In December, 1889, the scalp had become completely denuded with the exception of two or three tufts over the occiput. I ordered the scalp

closely shaven preliminary to fitting the patient with a wig. During a period of nearly eighteen months these scattered hairs remained fixed *in situ*, showing as black points on the white surface, but not protruding sufficiently to permit of their being grasped by the forceps. They simply remained motionless, without signs of vitality, *cadavérisés* in their sheaths, as Besnier has expressed it, until after the attack of measles referred to, when they were protruded and expelled by the new growth of hair coming up from the follicles. The mode of expulsion suggested analogies with the extrusion of the deciduous teeth by the upward growth of the permanent teeth.

I extracted a number of these hairs and found them black, rigid, inelastic, without bulbous enlargement, atrophied at their radicular extremity and tapering to a point. This prolonged immobilization of the hairs in their sheaths would seem to indicate that the follicular structures were paralyzed into inactivity during a long period, there being a complete suspension of function without destructive structural change —this inertia being finally succeeded by a renewed movement of vitality and a resumption of the functions pertaining to the processes of nutrition and growth.

CASE II.—Miss B., æt. 20, a sister of the patient whose case has just been narrated, presented herself for treatment, June 30th, 1890. She was a delicate-looking young woman of the brunette type, whose general health had become somewhat impaired by four years' hard study.

Inquiry elicited the fact that when her brother was home on a holiday some months previously, they had been thrown much together and she had been in the habit of wearing his cap. Examination revealed quite a number of bald patches covering almost the entire scalp. A peculiarity of configuration was noted in the patches on the sides and vertex; instead of being circular, a number of these extended with oval or caudate prolongations, converging toward the apex of the cranium.

The clinical behavior of this case was much the same as in the former; the alopecic process entirely denuded the scalp and extended to the eyebrows, the hairs of the pubes, and other surfaces of the body. Whether because the patient came under observation before the morbid process had become so chronic or because she was at once placed under more favorable hygienic conditions, the results of treatment were much more promptly successful. The disease was arrested at many points where outbreaks had become manifest, in the eyebrows, for example, the pubes, and elsewhere. Within six months the patient had a most luxuriant growth of hair, thicker and more abundant, she declares, than ever before.

A feature of interest in this case, worthy of being noted for its comparative rarity, was the simultaneous development of vitiligo. When the patient first came under observation a large patch of vitiligo, two by three inches in diameter, was observed on the nape of the neck. Other patches of smaller dimensions appeared later on other portions of the body.

The coincidence of alopecia areata and vitiligo—an affection essentially and typically neurotic—would seem to suggest an identical pathological process, or at least a common causality of origin. The many analogies in their configuration, their mode of evolution, and their association with nervous debility as a predisponent cause or condition, doubtless led Cazenave to identify the two diseases and class alopecia areata as vitiligo capitis.

As is well known, the clinical monotony of alopecia areata is rarely relieved by variations from the typical mode of its evolution; and since the remaining five cases presented no features of interest to distinguish them from the ordinary run of cases, they will be referred to but briefly.

Case III.—R. P., æt. 32, dark-complexioned, general health good. Has an obstinate gleet depending upon stricture. The alopecia first began on the face. When he came under observation it had extended to the mustache, right eyebrow, and there were two or three spots on right temporal region. Under the influence of local stimulation the hair returned everywhere, except on bearded portion of face, when he discontinued treatment. He returned six months later with a new development upon the scalp, the left eyebrow, and upper lip, which was again submitted to treatment for three months, with favorable result.

Case IV.—Mrs. E. P., æt. 45, brunette of pronounced type. The disease was limited to a single large patch on right temporal region with two or three smaller patches in its neighborhood. Cured in three months.

Case V.—R. H., æt. 38, dark-complexioned man, general health good. Had several patches distributed variously over the scalp. Discharged cured after three months' treatment.

Case VI.—Mr. W., æt. 40, brought to me for consultation by Dr. ——, of Troy, N. Y. Disease limited to single large patch on right side of scalp. The doctor promised to report again if treatment was not successful. As no report was received the inference is that the treatment was successful.

Case VII.—Mr. R., æt. 35, referred to me by Dr. ——, of Holyoke, Mass. Large patch over the vertex, several patches on temporal and occipital regions. Under the influence of the treatment recommended there was a prompt regeneration of the hairs on affected surfaces.

The evident transmission of the disease from the first to the second of my cases naturally leads to a consideration of the etiology of alopecia areata. It is not my purpose to pass in review the arguments advanced in support of the two current hypotheses. From a theoretical standpoint the parasitic theory is alone in harmony with our present knowledge of the essential rôle played by germs in the transmission of all communicable diseases. The demonstration of the contagiousness of a disease carries with it strong presumptive proof of its parasitic nature. While admitting that an affection, indistinguishable in its clini-

cal appearances and course from typical alopecia areata may be caused by local traumatisms, nerve lesions, mental shocks, neuralgias, and general nervous debility, the percentage of cases of undoubted nervous origin is very small. The vast majority of cases of typical alopecia areata are, in the writer's opinion, caused by a specific germ. What may be the microscopical characters of this germ or the conditions which favor its propagation are yet unknown. Since the microsporon Audouini was put forward by Gruby in 1843 as the active agent in the production of alopecia areata, a numerous procession of parasites has been paraded before the profession, each claimed by its discoverer to be the pathogenetic agent, but after a brief day of recognition all have been relegated to the limbo of common cocci.

The parasites of Malassez and Courrèges, of Thin, or Robinson, of von Sehlen have shared the same fate.

But, although the microscope has failed to satisfactorily demonstrate the existence of the causa morbi, the clinical facts pointing to the spread of the disease by contagion are so numerous and well attested as to leave no possibility of doubt. The numerous well-authenticated epidemics of the disease, its outbreak in schools, convents, regiments, and families, as well as the fact of its transmission from one individual to another, must convince the most sceptical of its contagiousness. Equally conclusive is the effect of prophylactic measures in arresting its spread by suppressing sources of infection, precisely as in the case of tinea tonsurans.

Indeed its clinical behavior lends some support to the theory recently advanced by Radcliffe Crocker that, exception being made for a small contingent of cases of undoubted nervous origin, alopecia areata is caused by the trichophyton tonsurans and represents a variety of trichophytosis. While he claims that spores identical in objective characters with those of trichophytosis may be found in recent patches of alopecia, his theory of the etiological identity of the diseases is based upon clinical facts, such, for example, as the contagious character of the affection; alopecia areata may be contracted from tinea tonsurans, and *vice versa;* the transformation of patches of typical tinea into the smooth patches of alopecia areata, etc., the modified clinical appearances being due to the fact that in adult life the hairs are so altered in consistence as not to permit the penetration of the spores, which insinuate themselves between the root-sheaths, separating the hair from its centre of nutrition, and gradually leading to its atrophy and fall. Notwithstanding the clinical proofs interpreted by the distinguished author in favor of his theory, there are so many opposing facts that it must be dismissed as utterly untenable.

Quitting now the vexed question of etiology, we approach the part

of our subject where the partisans of both theories meet on more solid ground and where there is perfect accord as regards the prognostic indications, as well as the general principles upon which a rational treatment should be based. But even here we find a difference of opinion as regards the efficacy of treatment. By many authorities the element of time is considered the most essential factor in the cure of alopecia areata, and quite a subordinate importance is assigned to therapeutic measures. Kaposi asserts "that treatment neither abridges the duration of the disease nor prevents its breaking out in a new point."

A knowledge of the natural history of a disease furnishes, of course, the only criterion by which we can appreciate the therapeutic value of the measures employed in its treatment. The observation of alopecia areata on a large scale shows that while benign cases are often self-limited and the disease disappears under the alleviating influence of time alone, yet there are many cases which, abandoned to their own evolution, may persist almost indefinitely without manifesting any sign of improvement until an active therapeutic intervention turns the tide toward recovery. In recent cases which exhibit a tendency to extension, the efficacy of treatment is signally shown in the prompt arrest of the alopecic process.

General Treatment.—The importance of general or constitutional treatment is differently appreciated by different authorities. Many advocates of the parasitic theory condemn constitutional treatment as useless and unnecessary. Whatever may be the micro-organism of alopecia areata, the peculiarity of its pathogenetic mode, the pathological result is an impairment of the nutrition of the affected areas. The clinical phenomena—the smooth, pale patches, the anæmic skin, the collapsed hair follicles, and the arrest or suspension of their function—all point to the participation of the nervous system in their production. While neither food nor medicine exercises, so far as we can determine, any direct specific influence upon the nutrition and growth of the hair, yet we know that local nutritive processes are favorably influenced by hygienic and therapeutic measures which invigorate the general health and improve the general nutrition of the system. Especially in cases where the disease is generalized and protracted the effect of local treatment may be materially aided and energized by the exhibition of tonics and reconstituent remedies. In such cases local measures should be supplemented by ferruginous, nutritive, or nerve tonics, such as iron, quinine, cod-liver oil, phosphorus, strychnia, etc. In all cases where there is evidence of a loss of nerve tone I am accustomed to give the phosphide of zinc and strychnia; a combination of phosphorus, iron, and strychnia; or phosphoric acid with strychnia.

While alopecia areata is often associated with evidences of impaired

health, nervous debility, and a variety of constitutional disorders, it must be admitted that a large proportion of cases are apparently in good general health. It would seem hardly necessary to subject strong, robust individuals, in whom no signs of antecedent or existing disorder can be detected, to a methodic general treatment.

The judicious rule of conduct is to base the treatment upon the indications furnished by a study of each individual case. If there is evidence of constitutional derangement, it should be corrected by appropriate means. If the patient's general health is good, constitutional treatment is of subordinate importance.

Local Treatment.—Among authorities there is a general unanimity of opinion as to the essential principle involved in the local treatment of alopecia areata; it may be summed up in a single word, *stimulation*. Variations in treatment depend upon the choice of the numerous agents recommended for this purpose and the methods of application.

The general rule may be formulated that any agent capable of determining an irritation varying in intensity from rubefaction to superficial vesiculation may be indifferently employed. The degree of such irritation is a matter of importance. Substances, such as croton oil, capable of causing a deep-seated dermatitis, should be avoided, as there may result permanent loss of the hair from pustular inflammation of the follicular structures. That stimulating agents should be essentially parasiticidic is not deemed essential even by the adherents of the parasitic theory. Besnier, who may be regarded as one of the most prominent partisans of this theory, systematically excludes from his practice all agents which may be properly classed as parasiticides.

Coming now to the plan of treatment which has given the best results in my hands, I may say that it is subject to modifications in detail depending upon the extent of the disease, the rapidity of its progress, and other clinical features.

In the simpler, more benign cases, where the patches are limited in number and circumscribed in extent, the hair around the margin of each patch is ordered to be closely clipped. This permits of a more thorough inspection of the diseased area and facilitates the application of remedies. As the disease always advances by peripheral extension, the hairs in this "zone of protection," as it has been termed by Besnier, are subject to a modified form of epilation. The hair should be grasped lightly by the forceps, and if it readily yields it should be extracted. If it resists moderate traction, the grasp of the forceps should be relaxed and the hair allowed to remain. This tentative traction is an excellent test for the detection of diseased hairs and should be frequently resorted to during the course of treatment.

In recent cases, where the parasite has presumably not penetrated

sufficiently deep to escape its action, I am accustomed to employ chrysarobin, with or without the addition of salicylic acid, in traumaticin, or in the form of an ointment, to insure more thorough penetration. The strength of the preparation is chrysarobin eight to ten per cent, salicylic acid two to five per cent, in traumaticin or lard.

This should be applied every three or four days in sufficient strength to excite and maintain a moderate dermatitis. In some cases I have found this treatment alone sufficient to effect a cure. Formerly I was in the habit of blistering the surface with acetum cantharidis or other vesicant, but I have not found this severer treatment more efficient than the chrysarobin applications.

In cases where the disease is severe and more extensive, covering the greater part of the scalp, the hair should be closely cut or shaven and the entire surface should be treated with acetic acid mixed with chloroform or ether. I usually employ a mixture of equal parts, the relative proportion of the acetic acid being graduated to suit the reactive peculiarities of the tissues, which vary in different individuals, and even in the same individual, at different stages of the disease. Ordinarily a strength sufficient to produce the white nitrate of silver tint is employed. This superficial vesiculation thus occasioned is followed by a slight exfoliation of the epidermis.

Instead of this mixture of acetic acid and chloroform, which has the advantage of being readily prepared, the strength being increased or reduced by varying the proportions, the following formula, recommended by Besnier, may be used:

℞ Hydrate of chloral, ... 5 grams.
Officinal ether, ... 25 "
Acetic acid (crystals), ... 1–5 "
M.

These applications are repeated two or three times a week at first, and continued at longer intervals during the entire course of treatment.

In the intervals between these applications, which should be made by the physician and not intrusted to the patient, I direct the use of a stimulating oil to be applied once a day as follows: Oil of eucalyptus, oil of turpentine, each half an ounce; crude petroleum, one ounce; alcohol, one ounce. The application of this oil is to be followed by a thorough massage of the scalp for five minutes, which the patient can be instructed to perform. This massage insures the penetration of the oil and constitutes of itself a most effective stimulus to the scalp. Once a week or oftener the head should be thoroughly shampooed with the tincture of green soap.

At a later stage of the disease I frequently order the use of this

oil to be replaced by a sulphur ointment—or sulphur in combination with resorcin. I have also used daily douches and frictions with salt water, which I am inclined to believe favorably influence the growth of the hair.

In alopecia affecting the hairy structures of the face I also employ the acetic acid, but the strength of the preparation must be modified to adapt it to this more sensitive surface. An objection to its use in this region is that the rubefaction persists for some time and the resulting epidermic exfoliation is objectionable on cosmetic grounds. On this account I more frequently order daily frictions with tincture cantharides or tincture of capsicum in an equal quantity of glycerin.

For alopecia of the body the extensive surface contra-indicates the use of active irritants, and milder means are fortunately sufficient. The use of mercurial and tar soaps and the employment of sulphur baths are the only measures necessary.

Such, briefly in outline, is the method of treatment which I have for some time employed with invariably satisfactory results. In estimating its value I am aware that in alopecia areata it is difficult to differentiate between the effects of treatment and the self-limitation of the disease. The acetic acid I was led to employ from the observation of its effects in the Saint Louis Hospital and the claim, which I believe to be substantiated, that it has a marked pilotrophic influence, and that more than any other agent it increases the pigmentation of the hair. Crude petroleum I employ in all these cases, either in the above combination or with equal parts of brandy, gin, or alcohol, from a conviction derived from my observation of its use in other forms of alopecia that it is a most admirable stimulant to the pilary system and promotes the growth of the hair.

In addition to these remedies I have used a variety of other agents. Jaborandi I have employed in the form of an ointment and pilocarpine subcutaneously, without result so far as I could determine. Electricity I have experimented with extensively, without being able to persuade myself that it influenced favorably the alopecic process.

Selections.

The Modern Treatment of Syphilis. By JONATHAN HUTCHINSON, F.R.S., LL.D. (*The Practitioner*, June, 1891.)

I do not think that there can be any doubt whatever that during the last quarter of a century mercury has been steadily gaining the confidence of the profession and the public, as the one real remedy for syphilis. We have ceased to use it in the violent manner in which it was formerly employed, and we now give it chiefly by methods which entail little or no inconvenience

on the patient, and do not in any perceptible way disorder his health. What has been called "the abortive method" has rapidly come into favor, and many of us now aim at entirely preventing the occurrence of secondary manifestations. If a patient who comes under observation within six weeks of the date of contagion will follow out the rules of treatment given, and will submit himself to the regular supervision of some one competent to judge of his progress I believe there is not the slightest difficulty in nine cases out of ten in effecting an absolute suppression of the secondary stage. All that is necessary is that the patient shall take continuously such doses of mercury as he can bear just short of ptyalism. They must be sufficient to cause the rapid and complete disappearance of the primary phenomena. If these are allowed to linger, the secondary ones will inevitably follow.

There has been some debate as to whether mercury can be considered a specific for syphilis, and as to whether it can claim the title of an antidote. All depends upon our definition of these words. If we are to insist that nothing shall be called an antidote unless, like the schoolboy's sponge on his slate, it can wipe out the record at once and forever, then of course mercury is no antidote for syphilis. But the problem is a wholly different one. In attempting to suppress syphilis we are dealing with a living thing, with that which may be retarded in its development or crushed for a time and yet not wholly killed: and we may, I contend, fairly apply the terms antidote and specific to any influence which can be shown to possess powers of constantly preventing development. Whether such suppression shall be complete or incomplete will depend upon the details of its management. When I say that I consider mercury antidotal to syphilis, what is meant is this: that it exercises a restraining influence on the multiplication and development of the particulate virus upon which syphilis depends—that it is, in fact, in this, as in so many other directions, a germicide.

To speak of the details of the abortive treatment of syphilis I have only to repeat what I have said on former occasions and have already published. I still use one form of mercury to the almost total exclusion of all others, and still prefer to modify the frequency of the dose rather than the dose itself. Respecting the gray powder (*hydrargyrum cum creta*) I feel perfectly certain from long experience that it is efficient and that fewer inconveniences attach to its employment than to any other preparation of mercury. Blue-pill, which comes the nearest to it, is, I feel sure, both less efficient and more liable to disagree. Simplicity of prescription is an advantage not to be despised in the busy life of a surgeon. It saves a great deal of mental wear and tear to be able to rely upon simple remedies and to habitually prescribe the same thing for the same disease. Thus, although I have not the slightest doubt as to the efficacy of mercurial inunction, mercurial baths, hypodermic injections of mercury, or the internal administration of any one of its numerous salts, I never, for ordinary cases, use any one of them. A pill containing one grain of gray powder, with enough opium to prevent diarrhœa or griping, is my almost invariable prescription. This the patient is instructed to take at intervals varying from three times a day to every three or even two hours, according to its effect upon him. He is at the same time instructed to abstain from fruit, green vegetables, and everything else in the least likely to cause diarrhœa.

There are, it is to be admitted, certain patients who cannot take mercury in doses adequate to the cure of the disease. These present us with some of

our most difficult problems. If the susceptibility occurs in the form of tendency to diarrhœa it can usually be met by the liberal combination of opium with the gray powder, and by strict attention to diet. If these measures do not suffice we may then have resort to inunction or the vapor bath. Cases in which mercury produces or aggravates sores on the tonsils or in the pouches of the cheeks are more difficult to manage; for in these it matters but little in what form the remedy is used. In these a combination of iodide of potassium, with a very small dose of mercury, or even an entire substitution of the latter by the former, may be necessary. There are a few patients, fortunately a very few, in whom mercury, even in small doses, produces debility, emaciation, and neuralgic pains. In such, a combination of quinine and iron with the specific will be necessary. As a rule, and unless called for by special circumstances, it seems better not to combine tonics with mercury in the treatment of syphilis. I have a strong impression that their use necessitates the employment of larger doses.

It is an extremely difficult task to determine whether or not the whole course of syphilis is influenced for good by the artificial suppression of its early stages. It is scarcely possible to collect statistics to show whether tertiary symptoms are more common, or otherwise, in cases which have been treated with mercury efficiently and during long periods in the early stage. My impression is strong that patients well treated by mercury during the secondary stage have a better chance than others of escaping tertiary phenomena; but I dare not speak dogmatically. No one can, I suppose, doubt in the least that tertiary syphilis is a far milder disease now than it was in the days of our forefathers. We cannot, however, claim the unquestioned diminution of tertiary syphilis as being wholly or in main part a consequence of the improved methods of mercurial treatment. It is a victory which has been gained by the discovery of the virtues of iodide of potassium; and here it is fair to remark that the use of the iodides in modern practice complicates all our calculations, and makes it impossible to estimate with any accuracy the results of mercurial treatment alone. The tendency during the last ten or fifteen years, has been, however, if I mistake not, very decidedly to diminish the employment of the iodides, and to give instead of them small doses of mercury. We have ceased to fear mercury, and have begun to recognize the all-importance of modification of dose.

I have just spoken of the efficiency of the iodide of potassium in reference to the treatment of some forms of tertiary syphilis. It is especially used in cases of diseased bones, in lupoid affections of the skin, in gummata of the cellular tissue and muscles, and in affections of the nervous system. In comparison with mercury it has advantages and disadvantages. Among the latter I would lay stress upon the fact that it is to many persons distinctly a depressant. My impression is that many of these are permanently damaged in their nerve tone by its continued use. In some of these the substitution of the iodide of sodium, or of ammonium, for the potassium salt is an advantage, but I believe that they are neither of them so efficient in the cure of tertiary syphilis. A prescription which is a great favorite with me includes the whole three, and combines with them what should never be omitted—a small quantity of free ammonia. As regards the permanency of cures by the iodide there is a general impression that it is not so efficient as mercury. This impression was, however, I suspect, founded chiefly on its employment in the secondary stage. Of the tertiary phenomena, it is, I think, true that if

once cured by any agent they but seldom relapse. If only partially cured they invariably do so, as their cell elements are infective. Thus, a patch of syphilitic lupus, for instance, if once replaced by a sound and healthy scar, never relapses, but if the smallest portion be left unhealed the disease is sure to return. As regards the various salts which are combinations of iodine and mercury, I have little or nothing to say. From a belief that they are much less certain in their action than either mercury or iodine alone, and far more prone to disagree, I never order either the iodide or the biniodide of mercury. Not that I have the least doubt of their efficiency as anti-syphilitics, but that the other preparations appear to me to be more trustworthy.

I have recently been requested by an insurance society to formulate some rules for its guidance in reference to the acceptance of the lives of those who have suffered from syphilis. I advised that patients suffering from active secondary symptoms at the time of their application should always be made to wait until the symptoms disappeared. My reason for this was that it is always desirable to know whether the syphilitic patient bears specific treatment well or not, and also whether he is willing to be careful and attentive in following out the treatment. The need for caution even here is, I think, by no means imperative. Young men in the early stage of syphilis appear quite as likely to live as long as others, and, as I have already said, the effect of treatment seems to be, in not a few instances, to improve the health rather than otherwise.

As regards those who offer themselves for insurance, free from symptoms, but with the history of former syphilis, what has just been said may he held to imply that I would certainly not advise an insurance office to allow the fact to make any difference. If the patient had become definitely the subject of tertiary lesions, or if, owing to idiosyncrasy or imperfect treatment, his secondary stage has been allowed to linger, then it must be admitted that there is reason for being cautious. Even in these, however, my experience has been that the threatened man lives long. The number of those whose lives have really been shortened by syphilitic maladies has been, so far as my own personal experience goes, extremely small.

When the bones are severely affected in tertiary syphilis we encounter undoubtedly one of the most unhopeful conditions. In a few of these cases, in spite of treatment, or sometimes seemingly in consequence of it, the patient may pass into a state of cachexia which may end in death. This event is, however, extremely rare.

There are certain other conditions yet to be mentioned, which, in reference to life insurance, assume considerable importance; they are not, however, by any means wholly of a syphilitic nature. I allude to the cases in which there is a risk that cancer may supervene. Almost the whole of these are instances of cancer of the tongue, or at any rate in some part of the mouth. There can be, I think, not the slightest doubt that a patient who has suffered from syphilitic stomatitis, or, for the matter of that, from mercurial stomatitis, is, if he persists in the habit of smoking, much more likely than other men to develop chronic sores, which may in the end pass into cancer. It is, however, precisely because such chronic inflammation has ceased to be syphilitic, in a definite sense, that it has become dangerous. It is the smoker's mouth, rather than the syphilitic mouth, with which we have to deal. In the female sex (non-smokers) we meet with no cases whatever of this kind. In cases of sore tongue, or of bald tongue with chronic sclerosis, in patients who have

had syphilis, and who persist in smoking, insurance offices ought certainly to exercise great caution.

There are certain affections which appear to be related to syphilis, although not directly dependent upon it, in which it is a predisponent, though scarcely an efficient cause. Among these I would venture to count locomotor ataxy and general paralysis of the insane. We seldom see ataxy excepting in those who have had syphilis, but—and this is most important additional statement—we scarcely ever see it excepting in men. If syphilis is a predisponent, it is tolerably clear that there is something in connection with sex which acts as the exciting cause. The development of locomotor ataxy is but rarely such as would lead us to believe that it is wholly due to any form of inflammation in connection with syphilis. We know of no other syphilitic disease which develops itself so slowly and insidiously. I fear it must be confessed that the results of specific treatment confirm the inference that it is by no means a direct outcome of specific disease. If I were to quote the cases in which white atrophy of the optic nerves has occurred as a complication, I am afraid I should be obliged to confess that they have all advanced to blindness in spite of the remedy. It has not, however, been so in those cases in which ophthalmoplegia externa or paralysis of single muscles of the eyeball have been the complicating conditions. In nearly all these, great benefit has appeared to result from the long-continued use of specifics. In these latter, the iodide of potassium, as well as mercury, is often very beneficial; whereas, in locomotor ataxy itself, I think I have often seen it prove definitely prejudicial, depressing the patient's vigor, and making him feel low-spirited and miserable, without in any way mitigating his symptoms. In general paralysis of the insane, if there is a history of syphilitic antecedents, I would never omit the long-continued use of mercury. I have seen great benefit from its employment, and when we remember that its most common pathological condition is adhesion of the pia mater to the gray matter of the convolutions (implying the existence of a low form of inflammation), we may easily believe that, if not required as a specific, mercury may still very possibly be of use. It should be given as a long course of small doses.

My belief as regards the association of locomotor ataxy with syphilis is that probably the nerve substance sustains during the secondary stage of the disease some damage, which renders it more prone to take on degenerative changes. Probably some low form of inflammation precedes the latter. The exciting cause is probably excess, sometimes as regards walking and standing, but more frequent in respect to the sexual function. Thus, the nerve structures may be considered to be more vulnerable and less capable of bearing the wear and tear of life than they were before the attack of syphilis. This suggestion, I believe, may be held to explain a certain number of other affections which occur in syphilitic subjects, but do not develop on the syphilitic pattern, and which are not easily influenced by specific treatment. Certain affections of the palms and soles, evoked by much standing, or by the irritation of tools, and persisting, in spite of treatment, for many years, may be quoted as examples of this.

I have not as yet adverted to the treatment of syphilis in its inherited forms. In infants, inunction is easily practised in a variety of ways, and is usually very effectual. I have also found a solution of the bichloride, in small doses, a very efficient remedy, and not so liable to purge as the gray powder. If there is any evidence of bone disease, the iodide of potassium

should be combined with it. If the symptoms are severe, and especially if the viscera are involved, infantile syphilis is undoubtedly a dangerous disease, and apt to terminate fatally by marasmus or convulsions. If, however, the specific is well borne, and the child passes favorably through the secondary stage, then I think there is, as a rule, very little danger of relapse: and a condition of good health may be expected until, at a later period, say eight to fifteen years of age, the liability to keratitis, deafness, phagedænic affections of the throat, etc., may come on. These late manifestations of inherited taint occupy, in reference to treatment, a most exceptional position. Although we always prescribe specifics, they seldom or never appear to exercise any definite power. Keratitis will often run its course apparently almost uninfluenced, or the second eye may be attacked while the patient is under the remedies employed for the cure of the first. As regards the deafness, unless the remedies are used in its very earliest stage, I fear they very seldom prove of any value. It is certainly to be strongly urged, in reference to both the deafness and the keratitis, that mercury and iodides should be prescribed promptly and liberally, but we must be prepared to encounter much disappointment, and to forego all hope of the rapid cures which the same remedies often effect in other conditions. It may be well that we should remember, in reference to this class of maladies, that they occur in those in whom probably the syphilitic virus has long ceased to be active, and who would be quite incapable of conveying the disease by contagion. They are tissue maladies, not the result of existing blood-poisoning. Hence, probably, in part, the impotence of mercury to manifest its specific power. There is no microbe left for it to kill.

Buccal Blennorrhagia in the New-Born. M. DOHRN. (*Le Mercredi Médical*, July 15th, 1891.)

M. Dohrn made an interesting communication to the Fourth Congress of the German Society of Gynecology upon the above subject.

The first case, that of an infant eight days old, observed last January, was reported in detail. Eroded patches were observed upon the dorsum of the tongue, the alveolar borders, and the roof of the palate, which were covered with a sort of grayish-yellow coating. As the mother had a quite manifest gonorrhœa, and the child was at the same time suffering from gonorrhœal ophthalmia, the condition of the mouth attracted particular attention. The detached flakes of the diseased mucous membrane were submitted to microscopic examination; and the presence of gonococci, verified by culture, was established. Four weeks later the eroded patches had become cicatrized, and all traces of the disease had disappeared.

In the course of the spring four new cases came under observation: the mothers were all affected with gonorrhœa, and examination disclosed a similar condition as detailed in the first case.

These lesions are without doubt frequently observed, but the proof of their gonorrhœal origin has not been demonstrated. The belief is generally entertained that the interior surface of the mouth is not apt to receive the gonorrhœal virus. In the case of the new-born these assertions are not exact, for in them the gonococci may penetrate deeply between the cells to parts of the mucous membrane, which, as a result of a mechanical lesion, are peculiarly exposed to lose their superficial epithelial cells, and this penetration of the gonococci may determine a slight desquamation of the affected parts.

Psorospermosis in the Rabbit's Liver. L. MALASSEZ. (*Arch. de Méd. Expér.*, III., 1891, No. 1.)

The rôle which certain animal parasites, notably the coccidia, play in the production of morbid changes in the human subject—psorospermosis follicularis Darier, Paget's disease, molluscum contagiosum—has recently been the subject of so much discussion, in which the facts themselves, or at least their interpretation, have been questioned, that a study of the indubitable psorosperms in the rabbit's liver, by one so thoroughly *au fait* in this field as Prof. Malassez, forms a welcome contribution to the discussion, even though little entirely new is added. The limitations of this notice preclude the possibility of an extended review of the author's paper; for the details the reader is referred to the original article. It must suffice here to note simply the heads which the author discusses. These are: 1. Epithelial and connective-tissue proliferation coinciding with the presence of the coccidia in the lumen of the biliary canals; 2. Invasion of the epithelium, vegetation, and dilatation of the ducts; 3. Different forms of non-encysted coccidia; resemblance of some of them to cells found in their diverse pathological conditions; their multiplication; 4. Destruction of the epithelium, encystment of the coccidia; 5. Coccidia encysted in the connective-tissue spaces, their struggle with giant cells; 6. Different forms of encysted coccidia, their reactions and their resistance to various agents.

As to the larger question, the rôle which these and allied protozoa play in the production of the diseases mentioned, the author, while he appears on the whole to favor the theory of their pathogenic signification, expresses himself very reservedly. We are not able, he says, in the present state of our ignorance of even the life-history of many of these organisms, either to affirm or to deny the possibility of a causal connection between them and the pathological conditions referred to. S. POLLITZER.

Syphilitic Diseases of the Spinal Column. DR. JASINSKI. (*Archiv für Derm. und Syphilis*, No. 3, 1891.)

The author maintains (1) that syphilis of the spinal column occurs under the forms of periostitis, ostitis gummosa, caries, exostosis, and necrosis; and (2) that it is a relatively very rare affection when diagnosis is established beyond a doubt.

A number of personal cases are reported, one of perispondylitis syphilitica; one of gummous inflammation of the periosteum and bodies of the cervical vertebræ, which was cured by immobilization, with a plaster-of-Paris dressing, and inunctions combined with large doses of iodide.

Several instances of spinal affection in children are given and the literature of the subject is reviewed at some length. CHARLES W. ALLEN.

So-called Circumscribed Atrophy of the Skin after Secondary Syphilis. DR. OPPENHEIMER. (*Archiv für Dermat. und Syph.*, No. 3, 1891.)

The author describes a case in which there occurred after a maculo-papular and in part a crusto-ulcerating secondary syphilide, pigmentation spots on the extremities and trunk which were for the most part pea-sized, but upon the abdomen were confluent and formed maplike areas of pigmentation. The color was brownish-red upon the lower extremities, but upon the abdomen, in the axillary regions, and the upper arms the spots were blue, so that not only from their color, but from the localization as well, one was forced to think

of *taches bleues* from the presence of pediculi. Careful inspection, however, showed that, while some spots were slightly raised above the surface and others were on a level with the skin, there were upon the upper arms spots which were about a millimetre below the skin level, so that they appeared like retracted scars. This, and the absence of pediculi, excluded the latter as a causative agent.

Another noticeable feature was the laxity of the skin, shown in the production of numerous folds and furrows which corresponded with the natural lines of the skin as given by Langer.

Upon the back several parallel furrows, in groups corresponding to the direction of the ribs, were to be seen. Under cocaine applied to the skin and made to penetrate by means of kataphoresis (the positive electrode of the galvanic current being employed) two pieces were excised from the arm and abdomen where there had been no preceding ulceration.

Microscopic examination showed all the vessels markedly infiltrated and in some sections the whole papilla was filled with round cells, and the lumen the vessels was no longer visible.

The epidermis was somewhat thinned and the papillæ in many places were flattened and fused together. Little change was found in the connective-tissue portion, and a definite decision upon the cause of the folds and depressions could not be arrived at from microscopical findings. Relatively little has been published upon partial circumscribed atrophy of the skin in secondary syphilis. Balzer, Nivet, and others are quoted, and the writer agrees with Balzer in regarding the atrophic spots as similar in appearance to the atrophic lines of pregnancy. But neither Balzer nor Nivet made microscopical examination, and the view is expressed that future observations will not show atrophy of the skin any more than was shown in the author's case. The process is regarded, on the contrary, as a thinning of the connective tissue from stretching, and that it will disappear in the course of time, leaving the skin with its normal appearance.

The author's case was seen again after two months, when some of the depressions had grown less noticeable and the blue color had in a measure disappeared. CHARLES W. ALLEN.

The Primary Cause of Death Following Burns of the Skin. DR. LUSTGARTEN. (*Medical Record*, Aug. 8th, 1891.)

The writer believes that an intoxication lies at the bottom of the fatal symptoms following burns of the cutaneous surface. The symptoms which come on within a few hours or days after the injury are those pointing to irritation of the vagus and cerebral contex and are succeeded by paralysis and death. They are best accounted for by some poison, produced in or about the eschar, gradually gaining access to the system. The conditions present favor the development of putrefaction and resoption.

Analogy and the clinical features of such cases point to a group of toxines to which belong neurin, muscarin, and allied bases derived from cholin. The great virulence of these is indicated by the fact that five milligrams of muscarin cause severe symptoms of poisoning in man, and the clinical picture in burns supports the idea of poisoning from ptomaines similar to muscarin. Other theories do not explain the paradox of deep burns with charring being relatively less dangerous than those which produce only white eschars.

Such charred tissue not undergoing putrefactive decomposition, the importance of the case is purely surgical. The author has made chemical analysis of eschar tissue. One-third of the skin of the thigh burned to a white eschar was subjected to Brieger's process. The peptone-free aqueous extract, obtained by the alcoholic sublimate precipitation, showed the general ptomaïne reaction. No marked poisonous effect was produced by it, however, when applied to the heart of a frog or injected into a rabbit. It was considered that an insufficient quantity of material was employed in the experiment, and it is thought that Brieger's method is less well adapted for quantitative results than for isolating particular ptomaines. With the knowledge that there exists between atropine and muscarin an antagonism, and that atropine neutralizes the toxic symptoms by paralyzing the nervous apparatus which muscarin has irritated, the author has employed atropia therapeutically in an extensive burn of the second degree after ominous symptoms appeared. Five milligrams were injected within two days, and the patient recovered.

The author deems this single positive observation worthy of special attention, since along with other bad symptoms vomiting had occurred, and it is stated that neither the elder Hebra nor Kaposi, with their extensive experience, ever saw recovery after this symptom had shown itself.

In two other cases, though the atropia undoubtedly kept the vomiting in check, the result was lethal. The author thinks it within the range of probabilities that with our increased knowledge of ptomaines we may soon be able to combat, by means of physiological antidotes, toxic substances from decomposition as well as from infectious diseases; the deleterious action of toxines, especially on the nervous system, being delayed until the organism shall have time to overcome the injurious substances.

CHARLES W. ALLEN.

Anthropometry in the Study of Syphilis. (*The Lancet*, Aug. 1st, 1891.)

DR. W. A. KOBYLIN has published an essay on the Use of Anthropometry in the Study of Syphilis, which may be taken as a contribution to the series of researches made at the instigation of Dr. E. Sperk, for many years in the Kalinkin Hospital, at St. Petersburg. In this hospital a large number of prostitutes are treated who voluntarily ask for admission, besides all those who are under official surveillance. All the observations made in this enormous number of cases are registered according to a system, to be made use of later on for scientific purposes. In his work, the author has closely examined the relations existing in five thousand people between height, weight, and temperature of the body on one hand, and the course of syphilis on the other, and he has come to the following conclusions: The liability to syphilitic infection is not the same in women of different heights. The most favorable mechanical conditions for infection are offered by small women, but these have greater immunity from attack. From sixteen to twenty years the mechanical conditions prevail, and after that age the immunity. Gummata impede growth; a syphilitic attack decreases weight. Mercury and iodides administered in the early stage increase weight. In the condylomatous stage general treatment more than counterbalances the loss of weight. The greatest loss of weight under the influence of syphilis, and the greatest increase of weight through general treatment, are found in the case of gummata. The essential syphilitic fever of Fournier is found in those relatively rare cases in which no perfect parallelism exists between external syphilitic

manifestations and the changes of temperature. Syphilis, Dr. Kobylin says, runs the most favorable course in women of medium height and weight, and the least favorable in women who are tall and stout, but proportionately light in weight.

On a Papular Acneiform Eruption, with Colloid Masses Resembling Those Found in Molluscum Contagiosum. J. F. PAYNE, M.D. (*British Journal of Dermatology*, August, 1891.)

The case is reported because it had certain resemblances to disease which was regarded as due to psorosperms.

The patient, a female, aged twenty-nine, presented an eruption on the forearms and hands, which had existed for a year and a half, and had lately spread somewhat rapidly. "It consisted of elevated conical papules, about twenty on each arm, hard, smooth, and pale, the size of small shot. The older ones were very hard, and showed considerable epidermic hypertrophy, but were not scaly, the superficial epidermis passing smoothly over them. Those said to be recent were not larger than a pinhead, and showed on careful examination a central depression, with a very minute orifice. A tiny drop of fluid could be squeezed from them, and if scratched (though there was scarcely any irritation) the papules would show a little moisture on the surface, or bleed; but there was no continuous exudation." The same papules remained unchanged during the whole course of the eruption.

They were distinguished from ordinary inflammatory papules by their permanence; they were unlike lichen, and differed from acne in the absence of comedones and sebaceous matter. Moreover, they were unconnected with the hair follicles.

They closely resembled warts, being largely composed of thickened epidermis.

The patient's general health was good, and there was no history of contagion. The eruption spread over the body like a progressive inoculation, as seen in molluscum contagiosum or in vegetable parasitic diseases.

It was cured by an application of salicylic acid collodion (30 grains to the ounce). The microscopic examination of an excised papule showed it to consist essentially of thickened epidermis.

In the deeper layers of the epidermis a number of highly refracting, pearly looking bodies, closely resembling the "molluscum bodies" were seen.

The author is disposed to regard the bodies as altered cells, probably the result of some local infective agent. Clinically the affection differed from molluscum contagiosum and from Darier's disease, though the bodies found were certainly like those described as psorosperms.

Diffuse Idiopathic Atrophy of the Skin. DR. KRISTIAN GROEN, of Christiania. (*Norsk Magazin for Laegevidenskaben*, No. 6, 1891.)

The writer communicated at a recent meeting of the Christiania Medical Society the following case of diffuse idiopathic atrophy of the skin:

N. N., sailor, forty-seven years of age, entered the Christiania Rigshospital with a cutaneous disease, diagnosed as eczema. The lower portion of both legs, especially the right, presented several small ulcers, with somewhat sharply defined and callous edges, while the skin lying between had a cicatricial appearance, and was covered with scales which varied from white to yellow in color. The skin, from five centimetres below Poupart's ligament

upon the anterior surface, and ten centimetres below the spine of the crest of the ilium upon the posterior surface down to the toes, respectively, the soles of the feet, presented a peculiar appearance. The borders upon the anterior surface of the left thigh were quite sharp and distinct, running parallel with Poupart's ligament, while upon the left thigh, both anteriorly and posteriorly, there was a portion of skin, a hand's breadth in width, where the skin gradually passed over into the normal. Below the boundary corresponded to the uppermost ends of the toes, so that the toes and soles of the feet anterior to the posterior border of the metatarsus had a normal cutaneous covering. The skin over the affected portion was thin, transparent, bluish-reddishly injected, and apparently devoid of all subcutaneous fat. The venous plexuses were very distinctly seen over the entire portion. If the patient stood or walked, they swelled up, and were apparently situated outside on the skin, while at the same time the abnormal skin seemed to assume a more cyanotic appearance. The greatest change was seen around the ankle joints and patellæ. Here there were a number of wrinkles and folds, which mostly had a transverse direction across the ankle and knee joints. These gave the skin an areolar appearance, as the folds were connected with one another. When the patient stood or walked, these would draw nearer to one another and become more distinct. If one should pinch up the skin here in folds it with difficulty smoothed itself out. The hairs on this portion of the skin were somewhat thin and few in number. He stated that he perspires upon both extremities. The muscles seemed somewhat atrophic, but there was no weakness. Sensation in the skin was on the whole normal. Otherwise the patient presented nothing else abnormal. The small ulcers healed in two months. The internal organs were found normal; neither sugar nor albumin were found in the urine. He stated that he had this skin affection as long as he could remember. He never had passed through any serious sickness, and, indeed, no cause could be discovered. His parents and family have always been well. F. H. PRITCHARD.

Alkalies in Universal Pruritus. C. LANGE, of Copenhagen. (*Hospitals Tidende*, No. 21, 1891.)

The author calls attention to the fact that most text-books present one with a most cheerless prospect in the section on universal pruritus. Arsenic internally and carbolic-acid compresses locally are the means most frequently relied upon. The writer has found a very prompt action in sodium bicarbonate combined with lithium carbonate in four cases of universal pruritus, namely, in two ladies, of which two were over fifty, and an old gentleman, in which cases the usual remedies had failed. The pruritus, in one case, in a fifty-one-year-old lady, who was formerly well, and by no means hysteric, which had localized itself in the genital region, was so severe that her friends feared that she would either lose her mind or throw herself out of the window. She became emaciated and hollow-eyed, and presented pruritus of the entire body. Only hot compresses, as hot as could be borne, with large doses of chloral, would produce sleep. The administration of the alkalies mentioned, together with carbolic-acid compresses, improved her condition in a few days; in six weeks she was markedly better, but still required hypnotics and a compress at night. In three months no more hypnotics were necessary. In the urine of two other patients an abundant precipitate of uric acid and urates was found. F. H. P.

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Original Communications.

A CASE OF EXCISION OF STRICTURE AND URETHROPLASTY FOR RADICAL CURE.[1]

BY E. L. KEYES, M.D.,
New York.

THE radical cure of stricture of the deep urethra is still an open question. The problem has been measurably solved for the anterior urethra chiefly through the energy and zeal of Professor Otis, and his persistent advocacy of extensive dilating urethrotomy. That solution is, thorough division of the contracted area, an operation which unquestionably very often yields permanent radical results. The same solution has not yet been proved to hold in the case of organic stricture of the deep urethra, nor has any other single rule been advanced to cover all cases.

I attempted to take a step in this direction two years ago before this society[2] by classifying organic stricture of the deep urethra into three groups—the soft, the cicatricial, and the inodular, and claimed that the soft was often curable permanently by dilatation, the cicatricial by thorough section on the floor and roof of the canal, while the inodular was incurable radically, unless excision with or without transplantation of foreign tissue was to offer a solution to the question.

I will recapitulate briefly.

The soft stricture we all know.

The patient presents every evidence of deep organic stricture, even, perhaps, to the extent of retention of urine. Small instruments may

[1] Read before the American Association of Andrology, Sept. 23d, 1891.

[2] The Question of the Radical Cure of Urethral Stricture. Med. Record, May 25th, 1889; read at the Third Annual Meeting of the American Association of Genito-Urinary Surgeons at Newport, May 21st, 1889.

fail to pass, no matter how carefully handled, and a filiform whalebone least of all. It comes against an obstruction, brings blood, causes pain, but fails to engage.

If the soft stricture be only moderately tight, a soft conical (not bulbous) woven bougie is more likely than any other instrument to find passage. Yet in these cases a moderately large, blunt steel sound if held gently, but with moderate even pressure against the face of the stricture, will very often suddenly break through a soft obstruction—a breakage which can be readily appreciated by the attentive, expectant, and intelligent hand—and will then glide readily on into the bladder, being very moderately grasped upon withdrawal. A little bright blood follows.

This sensation given by the blunt steel instrument, as it breaks through the obstacle, is something *sui generis*. It feels as if the mucous membrane had been lightly glued together, and the blunt instrument had evenly and softly, with a gliding motion, severed the sticky adhesions. It is totally different from that other sensation imparted to the sound in the same region of the urethra when the point impinges upon the edge of the triangular ligament, halts obstinately there for a time, and then suddenly, yielding either to skilful manipulation or steady pressure, hops with a sudden hard jump over the obstacle and then glides evenly on into the bladder.

In this case, commonly, no blood follows the withdrawal of the instrument, and there is no grasping of the sound on its attempted withdrawal. In this case there is commonly no stricture at all, but some dilatation of the bulbous urethra or some lack of skill in presenting the tip of the instrument exactly at the hole in the triangular ligament.

The soft stricture, then, which, by the way, is capable of immediate dilatation up to the full urethral calibre, I claim to exist and to be not very uncommon. You must all have recognized it. It may be pure and simple on the surface of the mucous membrane—doubtless a granular area loosely grown together on the surface. I have had no opportunity to verify this presumption by autopsy, but I believe it to exist pure and simple, cohesive surface adhesion with no surrounding inflammation and no cicatricial bands. The urine contains urethral pus shreds always in these subjects; signs of obstruction exist, subjective and objective; there is contraction, it is not fibrous, it is not spasm.

When this form of stricture exists in its simplicity, it is curable by simple dilatation, and radically curable, I believe, if the dilatation be pushed far enough and continued long enough to heal over the surface and cause the absolute disappearance of all the urethral pus shreds.

This, I think, I demonstrated by the citation of cases in my original paper. I maintain the same demonstration now to be a fact.

The objection to the general acceptance of this fact as being proved for deep urethral soft stricture is the undoubted coexistence of soft stricture, very often—indeed, most commonly—with more or less of the true fibrous cicatricial element within and beneath the soft, velvety covering of the stricture, so that, even if the granular area be healed and the stricture cured by dilatation, yet its compound element manifests itself later, the fibrous true underlying stricture recontracts unless kept open by occasional dilatation, and then finally the surface erosions and granulations reappear, and the stricture returns to its original condition, being anything but radically cured.

In the same original paper I demonstrated, by cases, not only that true traumatic linear stricture (or even broader annular bands in the deep urethra) might be and remain radically cured by extensive cutting through the perineum, but also that such formerly strictured areas would grow larger from year to year in a boy cut before the full size of the organ had been reached conformably to the increase in size of the calibre of the rest of the urethra.

I have no new facts to adduce here.

The inodular stricture at that time was a matter of doubt to me. It is still so. I do not indeed known whether a truly inodular stricture must have a gonorrhœal origin, or whether it may follow infiltration or must be due to a particular condition of the tissues of the individual possessing the stricture. Certain it is that these strictures most often have a gonorrhœal origin—but, indeed, for that matter, so do all strictures of the urethra, taken as a class; but is it a persistence of the gonococcus in the submucous tissues that entertains that quality of chronic inflammation that yields inodular tissue? I believe not, but am not sure.

The object of this paper is to present a case contributing to the study of the radical cure of deep urethral stricture of great extent, long duration, complicated by perineal fistulæ and by some tissue, apparently inodular.

This kind of tissue is useless and best done away with when possible.

Resection of the stricture, with union of the healthy urethral ends, has been many times practised and radical cure reported as a result. Heusner[1] operated on a case as long ago as June 1st, 1883; and three years later the patient, who had meantime used no urethral instrument, according to his statement, claimed by letter that he remained well.

Many other equally important observations are on record.

[1] Berl. Klin. Woch. and Sajous's Annual, 1888, vol. ii., p. 218.

Finally, Wölfler[1] not only cut away the offending strictured area, but details three cases in which, after allowing granulations to establish themselves evenly, he transplanted by Thiersch's method large pieces of mucous membrane derived from a prolapsed uterus, which happened to be on hand.

Wölfler alleges that all the grafts took, and reports radical cure in one year in one case without intervening instrumentation. One case was only of short observation; in the third, six months later, the patient died and autopsy confirmed radical cure. Wölfler later claims success in the same operation, by grafting such foreign material as the mucous membrane of the stomach of the frog, the œsophagus of the pigeon, the bladder of the rabbit—in each of which instances the mucous membrane detaches easily, and adheres without trouble in the human subject.

E. Meusel, of Gotha, has advanced our knowledge of the subject in that he reports a case in which he acted upon the fresh surface, not waiting for granulations to form. He used successfully the inner layer of the prepuce.

Bardenheuer[2] is claimed also to have employed the transplantation method with success.

My case, although not as perfect as I could wish, is yet of value, I think, in this connection. The result was far better than, I believe, I could have attained by any other method.

X——, aged 60, was sent to me by Dr. Schuyler, of Troy, on July 24th, 1890. Twenty-eight years before, he had fallen across a beam, and had had the usual subsequent history, of an aggravated kind, retention, abscess, infiltration, perineal fistula, etc.

There had been no previous infective inflammation of the urethra, as the patient stated; therefore, what moderate inodular material there was, could not have been due to the gonococcus. He had been operated on by perineal section after his infiltration, but close recontraction had followed.

When I examined him first, a fine filiform instrument could with difficulty be made to enter the bladder, but the urethra clasped it as if it were a nail in a board; and the urine, which was being constantly passed out under great straining and pain night and day, came away largely through perineal fistulous openings.

I laid open this stricture upon a whalebone filiform guide. It commenced in front of the bulb and extended well back under the

[1] Kong. der Deutsch. Gesell. f. Chir., April 5th, 1888. Wien. Med. Woch., May 19th, 1888.

[2] Sajous's Annual, 1889, C. ii.

pubic symphysis. The fistulous tracts through which he had urinated were upon either side of the incision.

The stricture itself was like a dense fibrous cord—or pipe rather—with a minute central calibre. The denseness and elasticity of this fibrous pipe, which was as large as a crow-quill and one and one-half inches long, was such that, although split open, it immediately sprang together upon itself, making again a closed fibrous canal at the bottom of the fresh cut. Here was a situation. Manifestly no dilatation would ever keep open this small fibrous canal, and my operation must certainly leave the patient with his stricture to grow again together, and with a false passage tunnelled beneath it through the cellular perineal tissues, to be maintained open or not, subsequently, as the case might be, in this old man of sixty, by subsequent dilatation.

Meusel's suggestion of immediate transplantation of the inner layer of the prepuce at once occurred to me. The patient fortunately had an abundant foreskin. I immediately disinfected it by vigorous washing and tying it up in a hot bichloride solution. I then cut out the stricture as carefully as possible, taking away all morbid tissue and dissecting out the fistulous tracts and all thickened inodular points. Then by hot applications and pressure, the bleeding, which had been very moderate, was staunched. Now a large piece of the inner layer of the prepuce, one and one-half by two inches, was rapidly cut away and cleaned, placed for a moment in a warm boric-acid solution, and rapidly sutured into place in the roof of the gap left by the excised stricture. Four points of catgut were used to attach it to the healthy urethral mucous membrane anteriorly; no sutures were placed posteriorly, as it was impossible to readily reach the prostatic urethral end, so far back had the excision gone. Several lateral points of catgut were also applied.

The parts were well dusted with iodoform, a large drainage-tube placed in the bladder and brought out through the perineal incision. Some vaselin dusted with iodoform over gauze was adjusted upon the flap, which was now cold and blue-white, and a large black, soft-rubber tube was carried through the entire length of the urethra and its end brought up against the drainage-tube as it emerged out of the bladder in the deep perineum. The object of this was to make firm pressure in a rounded way, so as to coapt the flap, which tended to hang down into the wound. Careful antiseptic packing was made about this tube and all confined in place under rather firm pressure by a mass of cotton retained by a T bandage.

On the fifth day all dressings were removed under irrigation, and the flap was found alive, of a dull gray-white color, and adherent everywhere, as far as could be made out by gentle manipulation, ex-

cept along a portion of the anterior edge, including one anterior angle, which flapped suspiciously to a moderate extent under the irrigating stream.

The parts were repacked antiseptically, and all dressings, including the vesical drainage-tube, removed on the eighth day.

Recovery was uninterrupted. Small shreds of whitish epithelium were shed off from time to time, but no portion of the graft in substance; and as long as the wound remained open, the thick, whitened epithelium of the flap could be distinctly seen at its bottom.

The perineal wound healed very promptly, so that in the middle of the third week after the operation the patient left the city for his home a hundred and sixty miles distant, with instructions to pass 32 French scale steel sound once a week until the wound healed in the perineum, and then at longer intervals.

The wound was closed in five weeks, but the patient thought that 12 English blunt steel sound (21 French) was large enough, and therefore he passed this size instead of 32 F. as directed.

He came back to see me in three months, declaring himself perfectly well.

I then passed gently a No. 27 blunt steel sound. It stopped a moment at four and one-half inches, then went on smoothly and again detected a moderate obstacle just past five and one-half inches.

Here, then, was a demonstration of partial cure: at the anterior edge where the flap had failed to unite by first intention, there was a moderate linear obstruction, then a smooth urethra, and again at the posterior edge of the flap, which had been too deep for me to unite by suture to the healthy urethra beyond, and where the coaptation was doubtless not effectively maintained by the perineal dressing, another, also moderate, linear obstacle; but the evidence also was that the cure was satisfactory in that the intervening urethra seemed clear and free.

At this time the patient could hold his water half a day and all night—a thing he had not been able to do for years. He had gained twenty pounds, and was immensely satisfied with his condition.

Having occasion to be in the neighborhood of this patient on September 16th, 1891, I sent for him to estimate his condition.

He is perfectly well, fat and strong. He urinates in a full stream, when inclined, by day, and sleeps the entire night. His urine is clear and free from shreds or pus.

I learned that he had continued to pass No. 21 (F.) blunt steel sound once a month, but had introduced no instrument for six weeks before I saw him.

I tested him with 27 blunt steel French scale, and found that it stopped in the curved urethra; then I passed the patient's No. 21 (F.)

blunt steel sound; it went easily, but clearly detected a linear, fine, fibrous strictured ring at about four and one-half inches, manifestly at the point of imperfect junction of the graft with the healthy urethra.

Beyond this point all seemed smooth and capacious.

While, therefore, I cannot consider this a case of radical cure—for I have not proved but that the present point of linear constriction will contract still further if left long enough to itself—yet the ease of the operation, and the facility with which the graft took, and the present admirable condition of the urethra, all speak loudly in praise of the method of treating long, tight, fibrous, and inodular strictures by the excision and grafting method.

109 East 34th Street.
Sept. 21st, 1891.

INFLAMMATORY STRICTURE OF THE URETERS.

By FRANCIS SEDGEWICK WATSON, M.D.,
Boston,
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THE rarity of stricture of the ureters of a simple inflammatory nature, to all appearances constituted in precisely the same way as are the very common strictures of the urethra, gives special interest to the few recorded cases of the condition. Having had two such cases in my own practice, I think it worth while to put them on record in detail, and to add a brief summary of the other cases which I have been able to find in the literature of the subject. This condition offers little or no suggestion in the way of beneficial treatment, nor, indeed, does it give much hope of the possibility of making a diagnosis from the few data that we have on hand. But as a matter of pathological interest it is worthy of note.

The following cases include all that I have been able to collect:

The first case in which I encountered this condition was reported in the Boston *Medical and Surgical Journal*, November 26th, 1885. The patient was a young man, æt. 21 years, who a year previous had had an attack of gonorrhœa lasting a few weeks, at the end of which time he was to all appearances entirely cured. He was a student at Cambridge, and during the winter following had been active in athletics, and a good student. A week before I saw him, he attended a boat-race. On coming home he had a chill, and within the next twelve hours the quantity of urine very materially diminished. During the next forty-eight hours he passed, in very small quantities at a time, only about fourteen ounces of urine, of low specific gravity, pale, con-

taining abundant sediment consisting of bladder epithelium, a few blood-corpuscles, pus, and mucus, and triple phosphate crystals. The urine also contained a trace of albumin. At the end of this time a tumor was noticed in the left hypochondrium, extending backward to the region of the kidney, and being apparently identified with it. At the end of the third day from the time of the beginning of the attack, this tumor was aspirated through the abdominal wall, and a large quantity of urine of a low specific gravity, with little sediment, was withdrawn. The tumor refilled within twelve hours. At the time I first saw the patient he was then in a distinctly uræmic condition, stupid, I think he could answer questions intelligently when roused. Tongue was thickly coated, urinous odor from the breath, muscular twitchings noticed in the forearms. A tumor of the size of a child's head at term could be easily made out in the region already described, and was evidently identified with the kidney. The bladder contained about one ounce of urine of the character already mentioned, and the patient's condition seemed desperate. After consultation with the family, it was decided to perform a lumbar nephrotomy, which was accordingly done. The kidney was reached through the usual perpendicular incision in the back. Upon opening the kidney through the cortex, a large quantity of urine gushed out through the wound and the finger entered a very large cavity, the farthest limits of which could not be felt. The ureter was explored for a long distance with a sound, but no obstruction was noticed in its course, nor was any stone found impacted in it, although the sound did not reach the bladder. The patient revived somewhat after the operation, and was, for a few hours after recovering from the ether, a little clearer, but died, at the end of forty-eight hours, of uræmic coma.

The autopsy, which was limited to the genito-urinary organs, showed that the right kidney was transformed into a big hole, a single sac, lined with pyogenic membrane, all the cortical substance of the kidney with the pyramids having been evidently destroyed some time previous by the chronic suppurative process. In the course of that ureter, one inch below its exit from the pelvis of the kidney, was found a dense deposit of connective tissue, originating probably from the chronic inflammatory process. The ureter was so narrowed at this point that it barely admitted a fine probe. The *left* kidney measured about fourteen centimetres in length, and was the seat of an extensive hydro-nephrosis; the cortex being thinned, and the organ converted into a series of large compartments. The ureter was widely dilated down to within an inch and one-half of the bladder. At this point was found a smaller deposit of connective tissue than that found in the right ureter, owing to which the calibre of the ureter at that point was similarly narrowed.

In this case there was a doubtful history of the passage of a renal calculus about eight months previous to death.

My second experience of this condition occurred on May 10th, 1890, when I was asked by Dr. L. F. Potter, of Malden, to see a man, 38 years of age, who presented the following history: "For eight or ten years he had had occasional attacks of pain in the right renal region of short duration. The pain was not severe, and not radiating. Six years ago he began to suffer from frequent and painful urination, and since that time there has been a gradual loss of flesh and appetite. At that time the urine became loaded with pus, and the patient occasionally noticed small clots of blood also in it. These symptoms have persisted in a greater or lesser degree ever since, occasionally being so severe as to confine him to bed for a fortnight at a time. For the most part, however, he has been able to attend to his business." When I first saw him, in May, his urine was pale, specific gravity varying from 1.010 to 1.020, with a large amount of sediment, which consisted of pus, few blood-corpuscles, bladder and renal epithelium. There was a large trace of albumin. In August the patient passed two small, smooth calculi, about the size of a pea, without any pain or preceding attack of renal colic. No relief of his symptoms followed. In February, 1891, the bladder irritability was so great that he demanded relief at any cost. After consultation with Dr. Potter, I advised drainage of the bladder in the hopes of securing this end. On March 4th the patient was etherized and the urethra opened in its membranous portion. The bladder was then explored digitally through the wound. (Cystoscopic examination had been impossible, owing to the fact that the patient's bladder could not be made to contain, even under ether, more than four fluid ounces of fluid, and it also was impossible to wash it clear of pus, which was present in great abundance.) The bladder was found to be trabeculated, and there was a superficial ulcerated surface in the vicinity of the left ureter. A large perineal drainage-tube was inserted and the bladder washed with a warm boracic-acid solution twice a day. Entire relief of pain and bladder irritability followed the operation. The patient did well for a week. He then had a mild attack of epididymitis on the left side. On the next day hiccough and vomiting developed. Rapid loss of strength ensued, and he died on the 15th of March, eleven days after the operation.

At the autopsy, the organs, with the exception of the genito-urinary tract, presented no pathological change of consequence. The bladder showed evidences of a chronic cystitis, and was markedly trabeculated, and the muscular walls of the bladder were thickened. The mouths of the ureters were patulous and wide, and the mucous membrane around them was swollen and œdematous. At a point about two inches above the bladder, the *left* ureter was obliterated by the dense deposit of connective tissue, which extended for about one and one-quarter inches in length. This mass occupied all the tissues of the urether from the mucous membrane outward, and constituted a true inflammatory stricture. Above this point the ureter was widely

dilated and chronically inflamed. The left kidney was represented by a thick-walled sac, lined with pyogenic membrane and showing no vestige of normal renal tissue. The right ureter was widely dilated from the bladder to within one-half inch of the kidney. At this point it was bent upon itself, and was occupied for a distance of about three-quarters of an inch by a mass of connective tissue similar to that described as situated in the left ureter; the calibre of the ureter being narrowed at this point so as only to admit of the passage of a large steel knitting-needle. The pelvis of the right kidney was slightly dilated. The organ was the seat of an extensive pyelo-nephritis, although a considerable portion of its cortex remained undestroyed. The capsule was thickened.

In addition to these two cases of my own are the following:

CASE III. (L. Galliard, *Progrès Médical*, 1880, Vol. VIII., page 868).—This patient was a man, aged 60 years, who a day or two before his entrance into the hospital had enjoyed excellent health, and never had any urinary symptoms. No history of renal calculus. On entrance there was continual pain localized about the lumbar region, and a fluctuating tumor could be made out there. The urine contained pus. Patient was constipated. The tumor increased slightly in size, and he died of uræmia four days from entrance.

The autopsy showed the left kidney to be the seat of an extensive hydro-nephrosis, due to the presence of an inflammatory stricture one and one-half centimetres long in the course of the ureter, just below its exit from the pelvis of the kidney. There was an extensive formation of connective tissue at the seat of the stricture. The condition of the other kidney was not mentioned.

CASE IV. (Ayroles, "Société Anatomique," Vol. LIX., page 214).—This patient was a robust-looking man, æt. 54 years. During the preceding two years he had passed several renal calculi. In the intervals between the attacks of renal colic he had been in good health. Ten days before admission he suffered from a sense of oppression in the abdomen, and for five days there had been total suppression of urine, which had persisted till the sixteenth day after entrance; the suppression of urine had lasted in all twenty-one days, at the end of which time he died; four hundred grams of urine, however, having been passed in the last twenty-four hours preceding his death. Œdema of the lungs occurred four days before death, and he was comatose during that time.

The autopsy showed obliteration of both ureters by the formation of a mass of connective tissue, resulting in stricture and occlusion.

CASE V. ("St. George Hospital Reports," Vol. X., 1879, p. 330).—A man, 22 years of age, had had no symptoms arising from the

urinary organs. A week before entrance developed night sweats, and wasted very rapidly. At the time of entrance the urine contained no albumin. Under treatment the patient improved for three weeks. Then albumin appeared in the urine. Œdema of the lungs and larynx supervened. Diarrhœa came on. Death took place a month from entrance.

After death there was found to be a stricture of the left ureter four inches below its exit from the kidney. The stricture was evidently not of ordinary formation. It was due to the deposition of connective tissue the result of chronic inflammation. Above it the mucous membrane of the ureter was thickened and swollen. Both kidneys were enlarged and the seat of a diffuse nephritis.

Case VI. (Boston *Medical and Surgical Journal*, April 4th, 1889).—The following case was reported by Dr. John W. Farlow, of Boston:

The patient was a married woman, æt. 35 years She had enjoyed apparent good health till June, 1887, when after exposure to a storm she was attacked with a backache and nausea. The latter persisted. In August occasional swelling of the face was noticed, and polyuria occurred at this time. In October the specific gravity of the urine was 1.010. It contained albumin. In the sediment were found epithelial cells, pus, a few hyaline and granular casts, and granular matter. In November an attack of suppression of urine occurred, lasting four days and nights. The urinary flow was then re-established and was very abundant. On December 15th suppression again occurred. When seen by Dr. Farlow on the 23d there had been no urine passed for eight days. No abdominal tumor could be made out. There had been no stool for fourteen days. Vomiting was constant and a slight œdema of the face existed. On examination per vaginam, a hard mass was felt in Douglas' fossa extending toward the left. This mass was still more noticeable when felt per rectum. It was tender on pressure. Suppression of urine continued five days longer; in all thirteen days. She then passed three ounces of urine, which contained albumin. On the next day she had convulsions, and on the 30th general slight convulsions followed within the next twenty-four hours. Twelve hours preceding these attacks she passed two quarts of urine, and during the day in which the convulsion occurred large quantities of urine were passed involuntarily. An abundant flow of urine of a low specific gravity occurred during the next ten days. Then suppression again came on and lasted one week. The flow was again established for eleven days, when it again ceased, and at the end of four days she died.

During the last three weeks of her life both kidneys could be made out through the abdomen.

At the autopsy, both ureters near their entrance into the bladder were found to be imbedded in a dense mass of fibrous tissue which

reduced their calibre so that a very fine probe partly passed. Connective tissue extended on either side into the broad ligaments. The ureters were moderately dilated above the strictures, as were also the pelves of the kidneys. The latter were pale, but showed no special pathological change. The bladder, rectum, and vagina were not connected in any way with the growth in the ureters.

NOTE RELATIVE TO PEMPHIGUS VEGETANS.[1]

BY JAMES NEVINS HYDE, A.M., M.D.,
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ON the 22d of April, 1891, Mme. A. S. came for consultation to the city of Chicago, accompanied by her husband. She presented a letter from her physician in Milwaukee, dated on the previous day, conveying the following information as to her history and condition:

The patient, a woman 33 years of age, had been for eighteen years under the observation of the writer. He stated that there was no family record of inherited disease. Mme. S. had seven brothers and sisters, all living and in health. In her ten years of married life she had become the mother of two living and healthy children. For several months before the date of the letter, she had been complaining of sores in the mouth, most numerous on the inner faces of the lips, cheeks, tongue, and soft palate, the hard palate always remaining free. These were roundish, circumscribed erosions, covered with a whitish film, which had been treated by pencillings with the nitrate of silver in solution, one gram to twenty. Temporary relief was thus secured, but soon followed by aggravation of all the symptoms, which included considerable soreness and difficulty in swallowing. No better results followed the use of several gargles employed. Two weeks before the date of the letter, its writer had been summoned on account of certain evidences of disease in the genital region, of which she had not for some time complained, on account of a feeling of delicacy. These were the seat of a burning pain. When examination of this region was made, a retroverted uterus was discovered, and a catarrhal condition of the vagina, but there were no symptoms of disease within the ostium vaginæ. The mons veneris, the labia majora, and the peri-anal region were covered with lesions almost identical in appearance with condylomata lata. The inner faces of the labia, and

[1] Read before the American Dermatological Association, Congress of American Physicians and Surgeons, at the Second Annual Meeting in Washington, D. C., September, 1891.

the parts within the immediate verge of the anus were unaffected. There was no adenopathy. The scalp was the seat of similar lesions. The mouth was in a worse condition than before; the erosions of its mucous membrane being large, numerous, and covered with a membranous film, beneath which was an hemorrhagic floor. The physician, suspecting that the case might prove to be one of syphilis, had with care questioned the husband, a gentleman known to him for twelve years, but had elicited no history of former luetic infection. The local treatment, to which resort was then made, consisted of the application of borax soap, followed by a white precipitate salve, four grams to thirty, with, internally, a tablespoonful of solution of the potassic iodide, two grams to one hundred and eighty. The result was so disastrous to the comfort of the patient and the condition of the skin that, though but a few doses of the remedy had been swallowed, the solution of the iodide was at once discontinued and the salve was examined by the apothecary who had prepared it, with a view to the detection of the presence of corrosive sublimate, as a result of which none was discovered. Meantime the general health of the patient seemed to decline; there was insomnia, inappetence, and mental despondency. As a consequence, the patient had been sent for consultation. Here ended the letter.

When examined, the patient was seen to be an intelligent woman, fairly well nourished, with a delicate skin. The inner faces of the cheeks, the sides of the tongue, and one or two points on the borders of the soft palate presented circumscribed erosions, of size and hue quite suggestive of the mucous patches of syphilis. Some of these were covered with a thin, whitish pellicle; others were raw and reddish excoriations of moist type. The tongue was coated with a whitish-yellow fur. There was marked soreness of the entire mouth and evident difficulty in swallowing.

The important skin symptoms were displayed over the ano-genital region, which was symmetrically and thickly covered with closely packed lesions having a distinct line of demarcation at the periphery of the entire group, and which strongly resembled agglomerated condylomata. The color of the whole patch was of the shade of mucous papules when freely secreting, a peculiar grayish-white hue. The vulvar and peri-anal regions were involved, with the corresponding mucous surfaces unaffected. Beyond the parts named, the patch spread slightly over the groins and over the line of juncture of the inner faces of the thighs with the perineum, to the extent of a hand-breadth down the former, and upward to about the same extent symmetrically over the pubes. Posteriorly, with equally well-defined border, the edge of the patch rose somewhat above the cleft of the

nates. Wherever the diseased surface abutted upon sound skin, there was a halo of intense hyperæmia. In brief, a well-marked dermatitis had been developed in the parts affected.

Over the scalp were thinly distributed split-pea-sized and smaller vesico-pustules, some of which had burst and been succeeded by crusts. Others were intact, and exhibited a slight crenation of the roof, not very unlike the umbilication of the vesico-pustule of variola. There was not a little tenderness of the scalp surface. The post-cervical and inguinal glands were moderately enlarged.

Comparing the scalp with the ano-genital lesions, it was not difficult to recognize the fact that the latter were for the most part fluid-containing elevations of the epidermis, both because puncture of several gave exit to a few drops of clear serum, and also because a few were distinctly visible with a ruptured roof-wall. But it was by no means clear that the disease was essentially one of bullous type, since the remedy administered internally and the applications made to the morbid surfaces had obscured, without question, some of the features of the disease, the local treatment in particular having produced a severe aggravation of symptoms, giving rise to an intense pruritus and greatly interfering with the comfort of the patient.

Moreover, it chanced that at the date of this examination the atmospheric temperature was unusually high, the patient having also presented herself immediately after a long railway ride in the heat, with a mass of cotton-wool firmly packed about the vulva and anus. Careful questioning of the husband elicited no history of venereal antecedents. A letter was accordingly returned to the physician in attendance, declining to make a diagnosis of the malady on the basis of the symptoms then presented, with a marked dermatitis added to the conditions produced by the pre-existing disease. It was added, however, that it was morally certain the patient was not a victim of syphilis: and that one could almost wish she were, seeing that we were unquestionably confronted with a more formidable disease, one probably of the well-known class of grave maladies in which pemphigoid lesions developed simultaneously in the oral cavity and elsewhere.

In response to this note her physician sent a report, dated April 27th, as follows:

"Two days after the return of the patient to her home, I discovered a large, well-developed bulla, with clear contents, upon one of the labia of the vulva; and in the course of the third day a number of similar but smaller lesions appeared on the upper and inner surfaces of the thighs. Posteriorly a very large crop of still smaller lesions appeared over the lumbar region, converting the entire surface into a red and inflamed field. Over a smaller area, the same process was

declared in the axillæ. The arsenic suggested in the way of internal treatment has been carefully pushed, and without deleterious results. There is marked insomnia, great soreness and difficulty in swallowing, and increased weakness. A severe intercurrent diarrhœa has been checked to-day. An offensive odor is making itself perceptible in the secretions."

On the 10th of May, in response to the appeals of both patient and physician, I visited the former at her residence in Milwaukee. She was found to be surrounded with all the comforts and many of the luxuries of home, attended by a trained nurse, and lying in a pleasant chamber with abundance of light and good air, in a house admirably situated from the hygienic point of view.

When examined, it was seen that the artificial ano-genital dermatitis, recognized at the date of the former observation, had subsided; and the lime-water and zinc dressings employed had sufficed to completely disclose the features of the morbid process. The outlines of the affected surface, as already described, had extended so as to produce a canoe-shaped patch, one point slightly above the umbilicus in front, the other at a corresponding point of the body posteriorly in the same plane. Between these two points a symmetrical curve with the concavity upward swept over the crests of the ilia. This line of demarcation was distinct, and the morbid surface thus defined was elevated to the extent of three or more millimetres above the plane of the adjacent sound skin. Only at one or two points was the regularity of this line of advance broken by the occurrence of an outlying pea- or bean-sized bulla, with pellucid contents of alkaline reaction, without a surrounding halo; globular, firm, well distended, and well rounded. Within its limits, this large and elevated patch was constituted of closely set lesions, leaving absolutely no sound skin between them. All were flattened and illy developed compressed bullæ, the macerated roofs of which, here and there ruptured and oozing, presented the peculiar grayish-white appearance of the condyloma; yet, at this time, it is scarcely necessary to say, the invasion of the surface was far greater than is ever seen in the most copious evolution of the syphilitic exanthem.

At the date of this examination, it was clear that the following was the order generally observed in the progression of the cutaneous symptoms: first, a bulla of pure type was developed, varying in size from a split-pea to a bean, without halo or inflammatory base: next, a copious development of numerous similar lesions, forming a patch with no unaffected area in its borders, the patch when fully formed having a surface elevated to the extent of several millimetres above the general level of the sound surface adjacent. Such a patch included

both ruptured and unruptured lesions, the general maceration resulting producing the appearance of the secreting condyloma. In the older portions of this patch, a darker-tinted crust began to form. At its defined edges there was, well-nigh invariably, a raw and reddish base, forming a moat-like depression at the edge, suggesting a line of superficial ulceration; and the single or multiple lesions, rising more or less abruptly from this erosive and reddish groove, had a characteristic papillomatous appearance, the moist, fungoid, or warty mass projecting itself to the extent of several millimetres above the plane on which it rested. The packing together of these papillomatous bodies made it much more difficult to study their evolution in the centre of the patch than, as here attempted, at the border. For, when central in situation, their close setting, and frequent capping with a macerated or relatively dry roof of a bullous lesion, rendered their identification difficult and hid their bases. The vegetating masses, however, succeeded to the bleb only when the latter had existed for some time, and in especial only when its primarily pellucid contents had become murky, clouded, and grayish, whether or not discharged by rupture of the roof-wall. The physician in attendance called my attention, at this time, also to a fact observed by himself, viz., that the extension of the disease is not invariably by the formation of new bullæ at the edge of the patch, but that often there occurred at its border, first an undermining of the epidermis by effused serum, scarcely sufficient to raise the stratum corneum from its attachments beneath, though usually sufficient to loosen and macerate it, then the projection upward of the underlying rete forming a warty growth; and lastly the occurrence of the excoriation of a vivid red, secreting a scanty serum encircling the base. In every instance, however, during the course of the disease, where its advances were made by irregular outcropping upon the sound skin, the lesions of newest date were purely bullous.

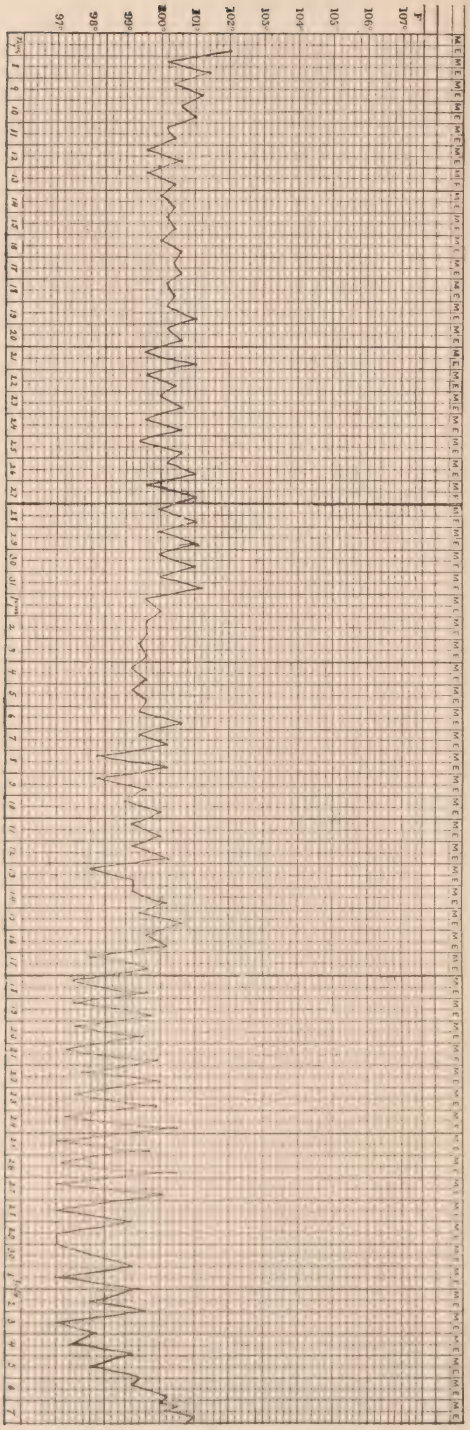
Upon the facts thus far detailed was based the diagnosis, pemphigus vegetans, the name first given to the malady by Neumann, of Vienna. In the pages which follow, an attempt is made to convey a picture of the striking features of the disorder as they were successively exhibited in its further evolution, this description being the fruit of observations made during the several subsequent visits made by me to the patient, as well as of the numerous reports sent me from day to day, by both her husband and her physician.

The region affected, next after the ano-genital (now better described as the integument covering the lower segment of the trunk and the inner faces of the upper third of the thighs) were the axillary and the cervical, in the order named, both being completely involved

at the date of the first visit. The axillæ were practically symmetrically covered, from the upper fourth of the inner faces of the arms to the corresponding line in the same plane of the trunk, and from above the axillary border in front to the same level posteriorly. The line of demarcation in each was fully as distinct as in the patch existing on the lower portion of the trunk, a few exceptions being here noticeable in the form of outcropping bullæ, pea- to marble-sized, with clear contents. The mass of the grouped and closely set lesions were flattish blebs and vegetating papillomata, a few of those still containing fluid, unruptured; a few desiccated and whitish-gray in hue, like the others; but the appearance of the condyloma was here less marked than elsewhere. Less distinct, also in this region, was the raw, secreting furrow encircling the isolated vegetating masses.

The cervical region was the seat of a singular group of lesions which resembled a collar or band fastened about the neck. It was from three to five inches broad, and completely surrounded the neck, extending from a point a trifle below the lower border of the larynx almost to the clavicles in front, and somewhat lower behind. The definition of the upper and lower borders of this collar were as distinctly defined against an unaffected skin as any of the lines, already described, respected by the disease. Within its limits were reddish and secreting excoriations; warty-looking elevations apparently springing from a base about which the epidermis had been peeled away in a ring of excoriation: and a few crusts, none of them bulky. The mouth was somewhat better than at the date of the last report from the patient. But there were still many raw patches and not a few sodden plaques of mucous membrane. The hair of the scalp had been cut short; and now there was no difficulty in discovering the vesico-pustules and crusts decidedly thicker than those seen elsewhere, which had covered this region. The odor was peculiar and nauseating—a symptom which became more pronounced and offensive as the case progressed. The patient meantime had grown decidedly weaker; the temperature-record is appended in a chart. Repeated and careful examination of the urine disclosed no renal complications. The menstrual period, now and after, was passed without flux.

By the 18th of May, bullæ began to appear also over the dorsal palmar and plantar surfaces of the hands and feet, the fingers and toes. In these regions, the mode of invasion of the disease was somewhat different from that observed in those parts of the integument where folds of the skin were more or less brought into apposition, as over the cruro-genital angles. Over the extremities, the blebs first appeared as quite large and well developed, perfectly isolated and well distended lesions such as are often seen in anæsthetic lepra, with



a slighter tendency to aggregation, though patches of this sort could be recognized over the instep and less well defined over the fingers. At about the same time, the popliteal spaces became involved, and the soft parts near the flexures of the elbows; the patches here formed spreading upward and downward over the limb rather more abundantly over the flexor aspects, never, however, to an extent sufficient to produce coalescence of the genito-crural with the advancing line of the popliteal area of invasion; nor of the axillary, with the newer developed patches spreading upward along the arm over the flexor aspect of the elbow joint. Steadily at the same time, the line of invasion described above as canoe-shaped in figure spread upward over the trunk, above the line of the umbilicus in front, and higher along the dorsal vertebræ behind. Meantime, happily enough, an improvement occurred in the condition of the mouth lesions, by reason of which the patient was enabled to swallow with greater comfort and thus secure better nutrition. At this time and for weeks after, the amount of food ingested was abundant and always of proper quality.

At the date of the next visit, May 23d, the genital region first invaded had un-

dergone a striking change, a change suggestive of the picture occasionally displayed in the later phases of pemphigus foliaceus. Yet there was a striking difference also between the two. Here the region first invaded exhibited an elevated, somewhat dry, rough, and irregular surface, in places warty, in others slightly crusted, only a few points representing abortive attempts at the formation of bullæ. As a whole, this surface was dry, dark brown in color, elevated, rough, and irregular.

The band or collar about the neck was undergoing precisely the same change. It was quite dry and free from bullæ, save at the defined borders, which exhibited a slight tendency to the production of fresh lesions. Examined with special care, this rough, deeply pigmented surface was seen to be composed of numerous closely set, wart-like, granulating elevations, the individual lesions fairly well defined in size, and but a trifle larger than the papules of eczema.

Meantime there was an active multiplication and spread of the disease over the back, partly, no doubt, in consequence of the enforced recumbent position for so much of the time; though the patient was now immersed in the continuous warm-water bath, for as long a period of each day as was found consistent with her health. A great deal of relief was thus secured; but, in spite of every precaution and all medicinal measures, there was always a large area over the dorsal and lumbar regions, raw, red, and exquisitely tender.

The maceration, as a consequence, of the healed and healing parts of the skin was unfortunate but apparently unavoidable, since it was found to be well-nigh impossible to keep the patient for any length of time lying upon the side. Many of the dusting powders, absorbent, antiseptic, soothing, astringent, were amply used but without conspicuous success. The large sensitive erosions of a brilliant reddish hue contrasted with the brownish and now well-nigh blackish shade of the elevated epidermis in the vicinity. The contrast was like that of an open wound upon the skin of the negro. While thus immersed for eight hours per diem or longer, the stools of the patient were normal, the urine unchanged, the appetite (for what could be ingested without great pain) fairly good, and the strength of the patient, though manifestly declining, on the whole wonderfully well sustained.

By the 7th of June, the new-formed bullæ were decidedly fewer, and the process of pigmentation in the roughened infiltrated and elevated patches was apparently at its height. If one may except a few spots near the vermilion border of the lips, where a few lesions had cropped out beyond the mouth and become covered with crusts, the face could be described as wholly unaffected up to this point; but now the brow and cheeks not only began to assume an exceedingly

dark tint—regions, it will be remembered, where no efflorescence of bullæ had occurred—but there also appeared innumerable comedo-like, blackish points in these localities, visible also below the chin on the upper part of the neck, above the collar or band of invasion already described in this part. The sorest and tenderest portions of the surface, the back always excepted, were now the exquisitely sensitive hands and feet, which it was necessary to support for much of the time in the prone position on cushions.

On the 25th of June I visited the patient with our colleague Dr. L. A. Duhring, of Philadelphia, who accompanied me from Chicago to Milwaukee for the purpose of making an examination of the patient, and who made several valuable suggestions respecting the management of her malady. Dr. Duhring had had the opportunity of carefully examining the portraits, in color, of the patient, made by Dr. H. Radcliffe Crocker, of London, the subject of a valuable and interesting monograph entitled "Pemphigus Vegetans (Neumann)," London, 1890. When I had last the pleasure of meeting Dr. Crocker, he had not prepared this pamphlet; but Dr. Duhring recognized the resemblance between the symptoms displayed before our eyes in Milwaukee and the London water-colors. Our patient was at this time in a fairly comfortable condition as compared with the past, and there was not occasion to note any special changes since the date of the last observation, save that the pulse and temperature-record gave promise of an amendment. The bullæ, still appearing in crops, were rather fewer and less aggressive, except possibly over the hands and feet; the pigmentation and warty roughness of the patches of older invasion were still strikingly conspicuous; the back was in places almost raw from the effects of decubitus; and though here and there could still be seen a free, isolated, well-rounded, and fully distended bulla of typical aspect, there was not the faintest suggestion, in any part, of the old picture presented where the skin appeared to be covered with condylomata. At the base of the elevated rim of several patches, there could still be found an undermined epidermis, from which a thin serum could be expressed, in the course of forming the excoriation so generally to be recognized at this line. By the 13th of July the patient was carried out of doors to get the air, enjoying herself in the sunlight for several hours, to her manifest advantage.

By the 20th of July there was a serious relapse. The places which, for want of a better term, have been here described as "healed," became again the seat of a fresh bullous efflorescence; at the same time the face and entire left upper extremity became enormously swollen, and the occurrence of sudden thrombosis was suspected. But by the constant attention and skill of her family physician, the patient was

rescued from this emergency, going on with progressively fewer obstacles to a convalescence which, though not fully established by the first of the current month, is at least promising. The general treatment of the patient internally was from the first by the employment of arsenic and iron. Locally a large number of articles were from time to time employed with varying results, including the use of the zinc oxide, sulphur, resorcin, the chloride of mercury, Fuller's earth, lycopodium, bismuth, and starch. The local treatment of highest value was, without question, the continuous immersion in water.

(To be continued.)

A CASE OF UNIVERSAL ERYTHEMA MULTIFORME.[1]

By LOUIS A. DUHRING, M.D.,
Professor of Skin Diseases University of Pennsylvania.

THE patient, a robust man, aged 29 years, has always had good health, and has never experienced any disease of the skin before. He was admitted to the medical ward of the Philadelphia Hospital, on June 3d, for unilateral rheumatism of the ankle and knee joint. He had complained of malaise for a week. The temperature was 101° F., and there was loss of appetite, headache, constipation, and slightly albuminous urine. The following night the eruption manifested itself suddenly on the flexor and extensor surfaces of the arms, on the face, back, chest, and palms, but not on the backs of the hands. The patches were erythematous, pea-sized, ill-defined, very numerous, more distinctly outlined on the face than on the arms, and were itchy from the beginning. The patient was restless, and scratched.

June 5th.—The eruption has increased in extent and intensity, being most marked on the chest and on the legs.

June 7th.—Patient yesterday complained of sore throat, and to-day this symptom is worse, and the tongue is dry and uniformly red. The pharynx is studded with raised, roundish, reddish patches, similar to those on the skin. Deglutition is difficult. The eruption of the general surface has spread, and is now becoming universal. The patient is restless and suffers malaise. The rheumatic pain lessened decidedly after the efflorescence began to appear.

June 9th.—The eruption is at its height. For the last two days the single lesions and patches have been coalescing. The body is almost universally invaded. The face shows a bright red, diffused erythema, without patches. Over the neck and on the anterior and

[1] Read before the American Dermatological Association, Sept. 24th, 1891.

posterior surfaces of the trunk down to the thighs there exist numerous coin-sized, roundish patches. The discrete lesions are slightly elevated, especially the borders. Some of them are marginate. On the backs of the hands and on the knuckles occur papulo-vesicles, showing typical erythema multiforme papulosum. The palms and soles manifest diffuse redness and swelling.

It is not necessary to describe the eruption more in detail at this stage. The diagnosis made was erythema multiforme of an unusual form. The subsequent course of the disease, however, was peculiar, and different from that usually noted in erythema multiforme, as will be observed.

June 11th.—The eruption has begun to fade and the itching is subsiding. The diet has been chiefly milk, notwithstanding which there has been nausea and vomiting. The general surface, especially where the skin is thin, has developed numerous minute, yellowish-grayish, superficial vesicles, such as are met with in scarlatina; and on the face there is a single pea-sized, flat pustule.

June 13th.—General desquamation is setting in, and recovery is manifestly taking place.

June 16th.—The desquamation is universal, the epidermis coming off in pieces and sheets of variable size. From the hands and feet are being cast off large exfoliative pieces, as in dermatitis exfoliativa, resembling, from the hands, parts of a glove, of which the fragments here presented are specimens. The patient henceforth made uncomplicated recovery.

The case is unique in my experience. The disease must be regarded as an erythema multiforme, for the reason that, for a few days before the height of the eruption, certain regions manifested unmistakable lesions of that affection. The portrait of the arm and hand here presented for inspection, was painted at this date, and, as we see, portrays erythema multiforme papulosum in its usual form, but subsequently the arms, hands, and fingers became completely covered with diffuse erythema. This was later followed by general exfoliation of the epidermis, taking place from the whole surface simultaneously, which need hardly be remarked is at variance with the ordinary course of erythema multiforme.

To recapitulate briefly, the disease was ushered in with and accompanied throughout its entire course with pronounced constitutional symptoms; it was general, attacking the mucous membranes, as well as the skin, and, from the involvement of the throat and the persistent nausea and vomiting, it is highly probable that the whole alimentary tract was similarly invaded. The eruption became universal and was of an erythematous type, with a tendency to papular and vesicular

formation in certain localities, followed by extensive and complete exfoliation of the epidermis. Its duration from beginning to end was about three weeks, and there was itching throughout this period. The diagnosis at first was obscure, erythema multiforme not suggesting itself until somewhat later; while the subsequent exfoliation of epidermis indicated that the process was allied to dermatitis exfoliativa. I regard the case as especially instructive as showing how closely some of these erythematous affections are related, and how occasionally so-called diseases may blend.

PEMPHIGUS FOLIACEUS MALIGNUS; THE SEQUEL.

By W. L. MUNRO, M.D.,
Surgeon to Out-Patients to the Rhode Island Hospital; and
G. T. SWARTS, M.D.,
Assistant Dermatologist to the Rhode Island Hospital, of Providence, R. I.

IN the September number of this JOURNAL we reported a typical case of pemphigus foliaceus. Those who were interested in reading that paper will find still greater interest in the following, and concluding, notes upon the case, illustrating, as they do, the treacherous nature of the disease, its terribly depressing constitutional effect, and the consequent necessity for a very guarded prognosis.

It will be remembered that we ventured a favorable prognosis based upon—

1st. Evident improvement in general condition, and

2d. Ability to heal over a raw surface as extensive, practically, as the back itself.

The report was sent to the JOURNAL August 15th. From that date the patient continued to improve, the back became drier, and, save a few patches the size of a dollar on the shoulders and hips, was covered with an apparently firm and healthy, though erythematous and pigmented, surface. Appetite and digestion continued good. There was no marked diminution, however, in the depression under which she labored.

September 4th she began to show signs of general weakness with loss of appetite and marked emaciation. The surface of the back began to secrete great quantities of serum, which, after a few days, became purulent in character. Diarrhœa and vomiting reappeared. Pain increased in severity. Temperature was subnormal.

September 10th the patient died of exhaustion, retaining consciousness until shortly before death. It was impossible to obtain an autopsy.

There had been no exacerbation of the disease as such, not more than half a dozen bullæ appearing in the last two weeks of her life. She had evidently passed the limit of her power to repair the ravages of the disease, and hence sank from exhaustion. Her symptoms at no time pointed toward septic infection. Death occurred about four and one-half months after she was first seen by one of us. From the clinical manifestations there was reason to believe that the alimentary canal was more or less involved throughout its whole extent and from an early period in the course of the disease.

No digestive disturbance whatever was observed following the application of the bichloride solution to the raw surfaces.

About two weeks prior to the patient's death, the raw surfaces being well healed, the moist bichloride dressings and oxide of zinc (powder) were omitted. Aristol was powdered freely over the whole surface of the back.

In view of the coincidence in time between this change in dressings and the abrupt change for the worse in the patient's condition, it would be interesting to inquire whether aristol, applied over large denuded or thinly cicatrized surfaces, can produce constitutional effects, and hence whether it may not have been a factor in the final issue of this case.

Society Transactions.

THE AMERICAN ASSOCIATION OF ANDROLOGY AND SYPHILOLOGY.

FIFTH ANNUAL MEETING, HELD AT WASHINGTON, D. C., SEPTEMBER 22D TO 25TH, 1891.

In the absence of the President, DR. F. N. OTIS, the chair was occupied by the Vice-President, DR. A. T. CABOT.

Reflex Irritations and Neuroses caused by Strictures of the Urethra in the Female. By DR. FESSENDEN N. OTIS, of New York. The author of this paper being in Europe, it was read by his son, Dr. W. K. Otis. Stricture of the urethra in the female, the author stated, has been so rarely considered or even referred to in works on the general diseases of females, or in the special diseases of the genito-urinary organs of the female, that it might hence be inferred to be a difficulty so rare or so unimportant as to be of little practical consequence. Symptoms in the female which in the male would be at once accepted as indicating the probable presence of urethral stricture, are often referred to under the title of "irritable bladder," and attributed to causes quite independent of their possible relations to the urethra. The fact that stricture of the male urethra is accepted as usually due either to gonorrhœal inflammation or to some traumatic cause, while the "irritable bladder" in the female occurs quite independently of any previous recognized inflammation

or injury, tends doubtless to prevent the consideration of stricture as a possible cause of the trouble. In regard to the origin of organic urethral strictures, either in the male or female, the author was thoroughly convinced that the foundation of at least the largest proportion consisted of cicatricial deposits due to lithiasis at periods often long antecedent to the gonorrhœa to which they are attributed. Dr. Otis then gave the histories of four cases of strictures of the urethra in the female, causing reflex troubles as varied and severe as those occasionally caused by strictures of the urethra in man. These patients were relieved by removal of the strictures. The author suggested the desirability of early exploration of the urethra by means of the urethrometer or the bulbous sound, in order promptly to eliminate at least one important element of failure in the diagnosis and treatment of such cases.

DR. ROBERT W. TAYLOR, of New York, stated that a number of cases of stricture of the urethra in the female had come under his observation, some as low as No. 4 F., and that two of these cases had occurred without known cause. In dividing these strictures he had used a small grooved probe, and cut them with a bistoury, and then practised dilatation. These patients presented no symptoms excepting those commonly caused by chancroidal growths at the meatus.

DR. JOHN P. BRYSON, of St. Louis, said that in the history of the first case given by Dr. Otis there was no statement as to whether the woman had borne children or not; whether instruments had been used, and, if so, by whom. These he considered potent causes of stricture in the female. Regarding the statement made that gouty or rheumatic diathesis underlies the largest proportion of strictures, the speaker doubted if it had more than an indirect influence in their production, by increasing the development of fibrous tissue.

Genital Chancres in Women. DR. ROBERT W. TAYLOR, of New York, read a paper with this title. Extra-genital chancres, the author said, occur more frequently in women than they do in men. In women they are less regular in their course, and are often so small, benign, and ephemeral that they may never be seen or their nature not suspected. For clinical purposes, genital chancres in women are classed as follows:

FIRST: The superficial or chancrous erosion. This appears first on the mucous membrane, and is very liable to be mistaken for a ruptured herpetic vesicle, an abrasion, or a scratch. It is so benign in appearance that its nature is frequently not determined at the first examination. It begins as a red spot, somewhat deeper in color than the mucous membrane on which it is seated. The secretion of this chancre is usually serous in character, or, when it is irritated, it may secrete true pus. Often no evidence of induration can be felt. A striking peculiarity of the chancrous erosion is its short period of existence. It frequently comes and goes without the knowledge of its bearer, and leaves no evidence of a cicatrix.

SECOND: The scaling papule or tubercle. This lesion is found upon the outer surface of the labia majora, upon the labia minora, upon the prepuce of the clitoris, upon the internal surface of the thighs, the inguinal folds, and the hypogastrium. It begins as a small, dull-red-colored papule, which may or may not be scaly and is usually not much elevated. It becomes brownish-red or purplish-brown in color, and has a sharply defined margin. It usually leaves a dark stain, and when irritated it loses its epidermal covering and

becomes raw and exuding. In rare cases the scaling papular chancre develops around a hair, and when this occurs it is not uncommon to see two or three or even more of these chancres. All chancres of this variety are slow in disappearing.

THIRD: The elevated papule or tubercle; ulcus elevatum. This chancre presents the appearance of a well-circumscribed flat or elevated lesion whose surface is similar to that of the chancrous erosion. It may be defined as a chancrous erosion in which the hyperplastic process has been more active and productive of much infiltration. The ulcus elevatum is seen upon the mucous surface of the labia majora and minora in its most typical form. It may become much hypertrophied, and around it may develop a greater or less amount of indurating œdema. It rarely shows marked induration.

FOURTH: The incrusted chancre. This is not uncommonly found upon the juxta-pudendal cutaneous surfaces, and indeed upon any portion of the integument. It has been stated that the incrusted chancres are not found within the area of the mucous membrane of the vulva, but it is not at all uncommon to find chancres in an incrusted state at the fourchette, and rarely they are found upon the clitoris and the labia minora when these structures have come to look like integument. This incrustation forms upon an eroded surface: it begins as a thin, white film, presenting a glistening appearance, and this increases in extent and thickness until a species of false membrane is formed which is wrongly called diphtheritic membrane. Then again we find, though very rarely, the chancre called by Fournier *chancre multicolore*, or the *chancre en cocarde*, in which the surface of the chancre presents a series of concentrated zones of different colors.

FIFTH: The indurated nodule. This form of chancre, so common in men, is very rare in women. In men the syphilitic neoplasm or nodule, as a rule, circumscribes itself in compact form into a little mass; in women this new growth tends to diffuse itself more loosely into the soft mucous tissues.

SIXTH: The diffuse exulcerated chancre. This is not infrequently observed in women of the lower order who are uncleanly in their habits and given to debauches. It presumably begins as a chancrous erosion and develops into the ulcus elevatum, and from this stage further develops. The appearance of this form of chancre varies. Sometimes it looks like raw beef, and at other times like an elephantine incrusted chancre.

As a rule, all chancres of the female genitals are unaccompanied with pain. Clerc never saw one, and Fournier says he never saw one seated beyond the vaginal ring. Bockhart reports a case of chancre in the middle portion of the vagina which had developed upon an excoriation produced by a tickler in ultralibidinous coitus.

DR. EDWARD R. PALMER, of Louisville, said that he had been interested in the remark made by Dr. Taylor with reference to the great frequency of extra-genital chancres in the female. The etiology of such chancres is simple enough. The speaker had heard the statement made that labial chancres (of the mouth) almost always involved the upper lip in perference to the lower, and he would like to get Dr. Taylor's opinion on this point.

DR. TAYLOR, in reply to Dr. Palmer, said that he considered the location of the chancre as largely a matter of chance. Of the labial chancres that he had seen, probably sixty per cent had been on the lower lip. He had seen one case where a chancre was located on both the upper and the lower lip.

In reply to a question by Dr. Bryson, Dr. Taylor stated that a tendency to great induration was generally observed just at the point where the mucous membrane leaves the corona and forms the prepuce. The induration about the glans itself is never very great, on account of some structural peculiarity it possesses. Where a chancre is situated at the verge of skin and mucous membrane, the portion of it in the skin is hard and nodular, while that in the mucous membrane is soft.

DR. J. BLAKE WHITE, of New York, inquired in what percentage of cases Dr. Taylor had observed the presence of a specific lesion high up in the vagina, notably at the cervix, where there was also a lesion in the posterior fissure of the vagina.

DR. TAYLOR replied that he had observed this in two or three instances, but that he regarded it simply as a coincidence.

Observations upon the Syphilitic Cachexia.—By DR. J. BLAKE WHITE, of New York.

On the Occurrence of Nephritis in Syphilis.[1]—By DR. JOHN A. FORDYCE, of New York.

Hereditary Syphilitic Transmission through Two Generations.—By DR. EDMUND E. KING, of Toronto. This paper was a reply to certain criticisms made by M. Diday, of Lyons, of Dr. King's previous paper on this subject, read to this Association in May, 1888.

The three foregoing papers were discussed together.

DR. TAYLOR said that he wished to challenge a remark made by Dr. White in his paper, to the effect that nature does not eliminate the poison of syphilis. Dr. White has overlooked the fact that syphilis may be aborted in either the first or second stage. Indurated nodules may resolve themselves without the supervention of secondary lesions. Animals are immune to syphilis, and there may be some persons who possess that immunity. There is sufficient clinical evidence to show that syphilis does abort itself sometimes. Dr. Taylor stated that he knows of patients who never had any evidence of syphilis nor impairment of health fifteen and even twenty years after the initial lesion appeared, and who never received any treatment whatever. There are some persons in whom the syphilitic virus runs riot, while others appear able to crush out the disease. The speaker said he thought Dr. White should add to his list of those who suffer markedly from the syphilitic cachexia the tall, thin, spider-looking fellows; also flabby individuals who possess a great succulence of tissue, and those with light red complexions.

With reference to the paper read by Dr. Fordyce, Dr. Taylor said that albuminuria was very common during the earlier stages of syphilis. Casts were rare, and, if any were found, they were of the hyaline character. The case reported by Dr. Fordyce he considered a very curious one, and thought it possible that some crisis arose, and that the syphilitic new growth was very active. He had never seen a similar case.

In reply to Dr. King's paper, Dr. Taylor stated that he was sorry to see that Dr. King nad again rehabilitated his case of syphilis in the third generation. He did not want to go on record as indorsing that case. The speaker said that of all the cases he had seen of syphilis in the third generation not one, upon investigation, was able to hold water. Atkinson's was a fairly good case, but it fell through. The full requirements must be fulfilled. The

[1] Will appear in a subsequent number of this JOURNAL.

author must establish, by a personal examination, that syphilis existed in one of the grandparents; he must establish a clear syphilitic history in the woman, and he must prove conclusively that the man who marries the woman is not syphilitic, because the father is a potent agent in syphilis. Unless these factors are fulfilled, the case is void.

DR. J. NEVINS HYDE, of Chicago, stated that he would like to indorse what Dr. Taylor had said with reference to syphilis being self-limited in certain cases. He had frequently seen cases—principally women—who had ignored the existence of syphilis, and who never suffered afterward from the disease. He had, in a few instances, seen patients with early syphilis taken down with incidental disorders, more particularly typhoid fever, in which the syphilitic symptoms were kept in abeyance during that time, and other cases in which there were no further signs of syphilis after the intervention of these intercurrent troubles.

DR. JOHN P. BRYSON stated that, in regard to syphilis of the kidney, he did not know how many cases of tertiary lesions of the kidney were on record. He has only had a single experience of that kind, where a diagnosis of possible abscess of the kidney was made. He cut down on the kidney, and, on palpating, his finger sank into it as if it was sinking into an œdematous lesion. This lesion extended down into the cavity of the pelvis. The cavity and ureter were washed out through the urethra from a stream above. Dr. Bryson said he had no doubt that many of the cases of so-called syphilitic cachexia were due to some local lesion that has, perhaps, escaped detection.

DR. J. BLAKE WHITE stated that he was pleased to see that his paper had elicited so much discussion. He said that, while he did not doubt that there were cases of self-limited syphilis, they were extremely rare, and must be considered as exceptions to the general rule. Many of these cases, too, were not kept under observation for a sufficiently long period of time, while others possibly developed some obscure lesions.

DR. FORDYCE said that, while he had not had an opportunity to thoroughly investigate the literature on the subject, he was under the impression that the prognosis was better in nephritis occurring in early syphilis than in the later stages. In tertiary syphilis he has observed amyloid degeneration of the kidney, as well as of the liver and spleen. In this amyloid form the prognosis was no better than when it occurred uncomplicated by syphilis.

Exhibition of New Instruments.—By DR. W. K. OTIS, of New York. Dr. Otis exhibited a new instrument which was made specially for the detection of hydrocele. It consisted of a small electric light, such as is used in the endoscope, in connection with a rubber tube. The light is pressed against the hydrocele, and the testicle is illuminated. It is also useful in supra-pubic cystotomy. Dr. Otis also exhibited an endoscope, composed simply of an electric lamp and a small screen to keep the light out of the observer's eyes. It throws a very good light and is of American make. He also showed an instrument, consisting of a handle with a number of bars or arms attached, which can be used instead of retractors in supra-pubic cystotomy.

Exhibition of an Antiseptic Syringe for Hypodermic Medication.—By DR. J. BLAKE WHITE, of New York.

A Case of Excision of Stricture and Urethroplasty for Radical Cure.[1]—By DR. EDWARD L. KEYES, of New York.

[1] See page 401.

DR. REGINALD HARRISON, of London, stated that his experience in the treatment of strictures by the process of excision was very limited, and that so far as it related to excision with grafting he had practically none. Dr. Keyes, he said, had presented a method of treatment which was likely to be of considerable value in a class of strictures which it was very difficult to deal with on account of the large amount of obstruction. Mr. Harrison said that while in Paris during the past summer he had seen M. Guyon treat a number of cases of traumatic stricture by excision. In these cases the extent of the obstruction was extremely limited. M. Guyon split open the stricture and got rid of the fibrous tissue, cutting it away with the curved scissors. The perineal wound was closed by three separate layers of sutures.

DR. BRYSON stated that he wished to say a word about the soft stricture referred to in Dr. Keyes' paper. He considered this as belonging among the sub-varieties of stricture, and consisting simply of a small amount of cicatricial tissue deposited just beneath the mucous membrane; outside of this there was usually found a considerable zone of more or less chronic inflammation going on. Another point he wished to refer to was the difference in curability between the linear and annular strictures. Very few annular strictures, he said, were cured by the ordinary methods employed, and he considered that Dr. Keyes had done admirably well by his patients.

DR. L. BOLTON BANGS said that in passing a bulbous bougie he had often felt the sensation of the soft stricture, as described by Dr. Keyes, and had seen, upon endoscopic examination, the adhesion of the two surfaces of mucous membrane.

DR. KEYES, in closing the discussion, said that suturing of recent traumatic strictures had been done for a number of years. M. Guyon's method, as related by Mr. Harrison, simply showed that he was working in the same direction. In suturing the perineal incision, Dr. Keyes thought it better to leave the skin open, simply bringing the mucous membrane together. In one case where he had closed the entire wound a blood-clot formed and was not discovered until some of the blood was strained out through the deeper stitches, and the patient had a very desperate time before he recovered. To avoid any such accidents he advises leaving the skin wound open, and then, if anything escapes, it can be seen.

A Contribution to the Surgical Treatment of Ruptures of the Bladder.—By DR. ARTHUR T. CABOT, of Boston. In this paper Dr. Cabot considered the conditions of extra-peritoneal ruptures of the bladder. The usual symptoms of rupture of the bladder, the author stated, were tolerably distinct, and the lesion could be demonstrated in most cases beyond doubt by the injection of air or fluid. This test sometimes failed when the rent was very small, or when there was a valvular closure of the bladder wound. Some authorities, the author said, advise that cases of extra-peritoneal rupture should be treated by simple drainage of the bladder, either through a perineal wound or by a retained catheter. This plan Dr. Cabot considered insufficient drainage for the urine which has already escaped into the tissues, or for the pus and masses of sloughing tissue which were certain to follow from the contact of urine. It was important for the operator to know where the rent in the bladder wall is situated, and in what direction the urine is forcing its way through the loose perivesical connective tissue. When this knowledge is obtained, he can make an opening into the extravasation from the nearest available point on the surface, and establish the most direct possible drainage.

An incision into the prevesical space, as suggested by Mr. Rivington, is only applicable in cases in which the rupture is in the front wall of the bladder and in which the effusion is slight. Another plan proposed in doubtful cases, Dr. Cabot stated, is to make a median cystotomy and with the finger in the bladder to search for the rents, but this method has in some instances proved unsuccessful. The best method of obtaining a knowledge of the condition of things in uncertain cases of extra-peritoneal rupture, the author said, is by opening the abdominal cavity and so getting an opportunity to thoroughly inspect and palpate the parts about the bladder. Dr. Cabot then gave the history of a case where an extra-peritoneal rupture of the bladder occurred during the operation of litholapaxy, which was at once discovered and treated by opening the abdomen, and he suggested that, in all cases where a rupture was made out, immediate action should be taken and a laparotomy performed, excepting where it was evident that the urine is extravasated into the prevesical space—where a supra-pubic incision is sufficient —or cases where the patient's condition is such that he cannot bear more than the median operation.

SIR WILLIAM MACCORMAC, of London, said that Dr. Cabot, in his paper, covered a great deal of ground and gave many valuable hints. The diagnosis of intra-peritoneal rupture of the bladder was, in many cases, easier than the extra-peritoneal. The speaker thought that the injection of fluid into the bladder as a means of diagnosis might increase the complications rather than diminish them; the injection of air he considered preferable. In two cases of rupture of the bladder coming under his observation there was an entire absence of the symptom that is mentioned in the text-books on this subject, namely, the extreme shock. In extra-peritoneal ruptures, when it is uncertain where the extravasation lies, ample drainage should be provided for. Circumstances must decide what to do in these cases.

MR. HARRISON, of London, said that he thought Dr. Cabot's case was a very instructive one. He was entirely in accord with the opinion expressed that extreme difficulty ofttimes attends the diagnosis of extra peritoneal rupture, especially those associated with fracture of the pelvis. A case of this kind had come under his observation where the bladder was punctured by a fracture of the pelvis; the fragments of bone returned into accurate apposition and the rupture of the bladder was not discovered until death occurred. Sometimes, the speaker said, it was very easy to make out a rupture by opening the perineum and putting your finger into the bladder. Extra-peritoneal ruptures were generally situated in the upper wall of the neck of the bladder; that is to say, in the bottom of the cellular space into which the finger passes when the bladder is opened about the pubes. In one or two instances where it had been necessary for Mr. Harrison to open into this space, he had also made a perineal section and introduced a drainage tube, with excellent results. Where, however, the bladder is ruptured in the lateral aspect of the neck, as in Dr. Cabot's case, his method of dealing with it by a lateral drainage from the groin was one likely to be attended with very good results.

DR. BANGS suggested that perhaps the cystoscope could be employed in locating rents in the bladder.

DR. KEYES stated that it was impracticable to employ the cystoscope in these cases, on account of the bleeding.

DR. BANGS said he appreciated this difficulty, but that it might perhaps be overcome by continual irrigation.

DR. CABOT called attention to the fact that the ruptured bladder would be collapsed and so not suitable for cystoscopy.

DR. WILLIAM H. HINGSTON, of Montreal, inquired why Dr. Cabot preferred the median lithotomy to the lateral.

DR. CABOT replied that he did not intend to speak of the median lithotomy except for draining the bladder, when he considered the median preferable to the lateral. Dr. Cabot thanked Sir William MacCormac and Mr. Harrison for the remarks they had made, and said he considered it a great privilege to have his paper listened to by one who has done so much to place the surgery of the bladder where it stands to-day.

On the Use of Salicylic Acid in the Treatment of Certain Forms of Cystitis.[1] By DR. JOHN P. BRYSON, of St. Louis.

DR. EDWARD R. PALMER, of Louisville, said that Dr. Bryson had related this incident to him a year ago in Altoona, and that since then he has had considerable favorable experience with the use of salicylic acid as an injection in cystitis. He wished to state, however, that in using Thiersch's solution—which is a combination of salicylic and boric acids—his patients often complained of very severe pain.

DR. BANGS said he was grateful for a hint which would enable him to so thoroughly clean out the bladder in old cases of cystitis. His experience with the use of Thiersch's solution was similar to that of Dr. Palmer. He supposed the strength of the solution was somewhat a matter of judgment.

DR. JAMES P. TUTTLE, of New York, said that he had used Thiersch's solution for the past three or four years for irrigating the bladder, and he desired to thank Dr. Bryson for telling him why he got such good results in those cases. In some cases, where the Thiersch's solution was very painful, he has afterward washed out the bladder with a mild solution of chloride of zinc, with excellent results.

Undetected Stone.—By DR. WILLIAM H. HINGSTON, of Montreal. Dr. Hingston stated that the difficulty sometimes experienced in locating a stone in the bladder is familiar to all surgeons. The most careful exploration may fail to reveal it. In examination for stone, the author stated that the bladder should be partially filled, and the patient could be made to empty it during the exploration, with the hope that the calculus, if there be any, will strike against the instrument. The slight difference in specific gravity between the calculus and the turbid fluid allows the stone to float about; and in that condition the sound or searcher does not elicit the characteristic "click" sought for.

DR. KEYES said that Dr. Hingston had not alluded to the washing-bottle and the small tube for the purpose of detecting stone. Another method is educating the finger to appreciate the gritty feeling, which he considers more important than the "click."

DR. BANGS said that he was in some cases enabled to detect stone in the bladder by means of the cystoscope. This failed in some cases, where the bladder wall was covered by a layer of tenacious mucus. This could be removed by the use of salicylic acid, as suggested by Dr. Bryson.

DR. KING mentioned a case where he had discovered a stone by means of

[1] Will be published in this Journal.

the cystoscope, after three surgeons had pronounced that there was no stone present.

Note upon a Possible Service to be Expected from Diuretin in Genito-Urinary Surgery.—By DR. EDWARD L. KEYES, of New York. In his paper, Dr. Keyes stated that, outside of the usual complications liable to attend cutting operations, the surgeon who deals with the genito-urinary tract has to contemplate and, if possible, guard against that other mysterious concomitant of operations upon the urethra and bladder known under various names, and often called urinary fever. The theories about it are numerous. To prevent urinary fever, the author stated, various things have been done, and among the drugs used for that purpose are aconite, quinine, and pilocarpine. These Dr. Keyes considers of very slight value to prevent the complications feared. Local urethral antisepsis with boric or benzoic acid, etc., he also considers to be very much overrated. Dr. Keyes then gave the history of a case which came under his observation last June. An operation was performed to take a large stone from the bladder of an old gentleman, and at the same time remove an outstanding third lobe. The outlook of the case after the operation was desperate, and before the patient recovered from the anæsthetic he was given ten grains of diuretin, and this dose was frequently repeated. This patient recovered, and since then Dr. Keyes has used diuretin in every case of urethral or bladder operation falling under his care. He gives sixty grains of salol a day for forty-eight hours before operating, and on the day of the operation begins giving ten grains of diuretin every four hours, continuing it for forty-eight hours. The author stated that while the use of diuretin in these cases must still be considered in the light of an experiment, he desired to say that since employing it he has never seen a chill or suppression of urine following operation. Diuretin, Dr. Keyes explained, is a combination of theobromine and salicylate of soda; it is a good diuretic and does not irritate the stomach nor depress a weak heart.

DR. HINGSTON stated that he thought the condition of the patient, especially of the bladder or the urethral canal, had much bearing upon urethral fever. All surgeons know that patients have their good days and their bad days. While urethral fever was absent in the vast majority of cases, he considered that any remedy that would help prevent it was very valuable.

DR. BANGS said that urethral fever seemed to be the result of the operation itself, a kind of shock; so that the patient, so to speak, poisoned himself. He had endeavored to account for several cases of urinary fever in this way.

DR. BRYSON inquired whether Dr. Keyes used diuretin in combination with morphine. It appeared to him that diuretin or some other medicine might have some effect on this alkaloidal poisonous principle which seemed to be in the blood, and which seemed to have some determining influence in urethral fever.

DR. KEYES, in closing the discussion, said that perhaps it was the diuretin which affected the neurotic element which he believes underlies the fever. He considered the fever as largely the result of shock. It certainly is not urinary intoxication. It rarely follows supra-pubic operations. Perhaps it is the diuretic principle of the drug which proves beneficial. The speaker said he uses diuretin constantly in combination with morphine.

Encysted Stone, Complicated with Growths of the Bladder.—By DR. C. H.

MASTIN, of Mobile. This paper was read by the Secretary. It gave the history of a case in which a growth was spontaneously expelled from the bladder eleven days after operation. Specimens were exhibited.

Hæmaturia.—DR. W. K. OTIS, of New York, read a paper with this title, in which he stated that the diagnosis of hæmaturia usually offers no great difficulties; the mechanism of micturition, chemical examination of the urine, instrumental exploration of the bladder, and, finally, the resorption test furnishing sufficient points for diagnosis. If the locality of the hemorrhage is in the anterior urethra, the blood will flow continuously. If it is situated in the posterior urethra—the pars prostatica—the flow of blood will not be continuous. The urine itself will be clear. If the point of hemorrhage is in the interior of the bladder, the blood is intimately intermixed with the urine. Blood clots in the urine—the long, coagula-like worms—indicate renal hemorrhage, representing casts of the ureters. If the coagula are short and broad, they originate in the bladder. If the specific gravity of the urine is low, renal hemorrhage is indicated: on the other hand, if it is normal or high, vesical hemorrhage. Vesical hemorrhage is also indicated when ammoniacal fermentation is present. If the microscope reveals casts containing blood-corpuscles, or hyaline casts, the hemorrhage is from the kidney; if only vesical epithelium is found, the hemorrhage is from the bladder. When the examination of the urine is negative, instrumental examination of the bladder and the resorption test are usually conclusive. Before making the instrumental test, the bladder should be thoroughly washed out; then, when the catheter is moved about, the bleeding will immediately commence anew if the point of hemorrhage lies in the bladder. The resorption test is made with a solution of potassium iodide, which is injected into the bladder by means of a soft catheter. It is an established fact that, if iodide of potassium is brought into contact with a point capable of resorption, iodide can be demonstrated in the saliva after a very short time—not more than fifteen minutes; and in hæmaturia this indicates that the hemorrhage is from the bladder. When the bleeding is not too profuse, the electro-cystoscope is of great value in establishing a positive diagnosis.

DR. TAYLOR stated that Dr. Otis might add to his paper a fact he already knows, and that is that in some severe cases of anterior urethritis a little blood might flow from the anterior urethra, due to the contraction of the muscular fibres upon the mucous membrane.

DR. J. WILLIAM WHITE, of Philadelphia, stated that he had once or twice tried the resorption test by means of potassium iodide, but had failed to get the reaction. He would like to inquire how reliable a test it is.

DR. OTIS said that he considered it a very reliable test: that whenever he had used it, the reaction had been very prompt.

DR. BRYSON said that he wished to call attention to the statement made by Dr. Otis to the effect that when the specific gravity of the urine was low it indicated a renal hemorrhage. He had seen many cases of renal hemorrhage where the specific gravity of the urine was still high, and remained fairly so. Further than this, in drawing off different layers of urine, we find that the specific gravity sometimes varies, and he considered it best not to lay too much stress upon this point.

DR. J. BLAKE WHITE wished to call attention to the importance of the fact, in the treatment of hæmaturia of the bladder, that the local congestion is kept up to a great degree by the presence of mucus. In those cases it has

been his practice to wash out the bladder with the sulpho-carbolate of soda and then apply silver nitrate, perhaps half a grain to the ounce.

DR. CABOT stated that this year three cases had come under his observation where it was important to make out whether the hemorrhage came from the kidney or the bladder. Two of these were cases of general abdominal injury. In the other case there was hæmaturia from a process which had been intermittent for a year and then became persistent. The patient was an old man; he complained of no pain or ache, and the kidneys were perfectly insensitive to pressure. In this case Dr. Cabot applied the test spoken of by Dr. Otis in his paper, first thoroughly washing out the bladder and then injecting a measured quantity of fluid; this was at once drawn off into a bottle, and the catheter transferred into another bottle; the first rush of water came out perfectly clear, and then the drops were uniformly tinted with blood: on the strength of this the bladder was eliminated as a source of the hemorrhage, and subsequent events proved the correctness of the diagnosis.

DR. OTIS considered it very difficult to make a diagnosis in cases where the hemorrhage is so profuse that you cannot do anything with it. The cystoscope cannot be used, and it is difficult to tell where the hemorrhage comes from.

DR. BRYSON inquired whether, in cases where the hemorrhage was so profuse that it was impossible to use the cystoscope, he did not feel satisfied that the patient had a vesical hemorrhage. Has he ever seen the blood coming so fast from the kidney?

DR. OTIS said that he had seen at least one case where the cystoscope could not be used on account of blood from the kidney.

Clinical Notes on: (*a*) Hypertrophy of the Prostatic Sphincter; (*b*) Relation of Rectal Distention to Arterial Depression.[1]—By DR. WILLIAM T. BELFIELD, of Chicago.

In his second paper Dr. Belfield stated that at a previous meeting of the Association he had mentioned the fact that irritation of the mucous membrane of the rectum in dogs produced a decided arterial depression, amounting sometimes to fifty per cent. Since then, he had noticed that in operations upon the bladder, or other operations where the rectal bag was employed, there was a marked lowering of arterial tension, which disappeared when the bag was withdrawn.

Notes on the Surgery of the Prostate.[1]—By DR. WILLIAM N. WISHARD, of Indianapolis.

The two preceding papers were discussed together.

DR. J. BLAKE WHITE said that a short time ago a patient came under his care who manifested very distressing symptoms of vesical irritability; the bladder and right ureter were made out to be in a dilated condition. Supra-pubic cystotomy was performed, and the prostatic sphincter was found to be contracted. The sphincter was dilated with the finger, drainage was kept up for fifteen days, and the patient made a satisfactory recovery. In regard to the value of the two methods of operation, supra-pubic and perineal, Dr. White said that he preferred the former where the drainage was necessary for a long time; urinary fistulæ are also less likely to occur, as the tissues contract more readily in that locality than about the perineum.

[1] Will appear in this JOURNAL.

DR. BANGS said that he was somewhat at a loss to understand what Dr. Belfield meant by the prostatic sphincter; whether he meant a distinct muscle, or a prolongation of that mass of muscular fibres which forms the vesical sphincter. He has in a number of cases practised over-dilatation or division of these fibres; that is, the immediate fibres surrounding the prostate and the vesical neck. Dr. Bangs said he considered Dr. Wishard's paper a very valuable contribution. The death rate in connection with prostatic surgery was considerable, and he has endeavored to discriminate very closely whether it was advisable to make a radical operation or use milder measures.

DR. BRYSON said he considered the papers just read both interesting and instructive. The relationship between these prostatic hypertrophies—or, better, myomata in the prostate gland—and the condition of the vesical muscle is of great importance. It is one of those questions that cannot be settled entirely by post-mortem researches. The speaker knew of no observations bearing directly upon the pathology of the change in the muscle, much less its etiology.

DR. BELFIELD, some years ago, had called attention to the fact that irritation about the vulva, genital organs, and rectum lowered the blood-pressure. Dr. Bryson did not consider this failure of the heart which follows operations about the bladder as merely a mechanical affair, but as a general nervous disturbance, perhaps in some way allied to urinary fever and as something which must be guarded against by the surgeon.

DR. W. K. OTIS stated that last year he had reported a case in which a tumor of the prostate was removed about the size of the end of a man's thumb, and eight ounces of residual urine was withdrawn. It is now about eighteen months since the operation, and the patient is in perfect health. Dr. Otis said that he had passed a catheter a short time ago and found no residual urine in the bladder.

DR. TUTTLE reported a case that he had seen in consultation with Dr. F. N. Otis and Dr. Keyes, where the prostate was found to be almost encapsulated in a thin layer of calcareous substance. In addition to this there was found that condition characterized by Dr. Belfield as hypertrophy of the prostatic sphincter.

Observations upon the Surgery of the Ureter.—By DR. ARTHUR T. CABOT, of Boston. These observations, Dr. Cabot stated, were the result of some investigations upon the anatomy of the ureter with reference to its surgical accessibility in different parts of its course, and with the especial object of determining how best to reach and remove impacted stones in the ureter. The author takes it for granted that, if possible, it is always best to use the extra-peritoneal incision for the removal of a stone. Dr. Cabot stated that the search for the ureter is much simplified by a knowledge of the fact—which he does not find mentioned in any description of its anatomy—that it is in relation with that part of the peritoneum which becomes adherent to the spine. After the ureter dips down into the pelvis, it is not so easily located, because it does not bear any fixed relation with a bony landmark, but fortunately, in the cases in which a stone is sought for, we have a hard body that is readily felt to guide us to it. To reach the ureter in the upper part of its course, Dr. Cabot said, perhaps no better incision can be chosen than that planned by Israel: he draws a line from a point on the anterior edge of the sacro-lumbar mass of muscles, just below the twelfth rib, and parallel to it.

Then turns downward toward the middle of Poupart's ligament to the line of incision usually made for tying the iliac artery; then again turning toward the middle line, and ending on the external border of the rectus muscle. According to the location of the calculus, the incision can be made on the posterior, middle, or anterior third of this line.

DR. ROSWELL PARK, of Buffalo, stated that he desired to thank Dr. Cabot for his excellent paper. He said that, while he has had no experience in the surgery of the ureters, he realized the accessibility of the ureter in operations on the lower part of the rectum.

DR. TUTTLE inquired how much of the sacrum was removed by Dr. Cabot.

DR. CABOT replied that the sacrum was removed as far up as the third foramen.

DR. WILLIAM T. BELFIELD, of Chicago, stated that, while he had no personal experience in connection with surgery of the ureter, he has had occasion to expose the neck of the bladder, and appreciates the advantages of the incision suggested by Dr. Cabot.

Exhibition of Complete Double Ureters of Both Kidneys.—DR. EDMUND E. KING, of Toronto, presented specimens of complete double ureters of both kidneys. Dr. King said that in ten post-mortem examinations made by him he had found three cases of supernumerary ureters.

The Dry Poultice in the Treatment of Epididymitis.[1]—By DR. GEORGE E. BREWER, of New York.

DR. BRYSON said he was very much interested in Dr. Brewer's paper, and especially in connection with the rapid absorption of the inflammatory induration, which is so apt to remain for a long time. Such good results are often obtained, however, without any treatment, that one is at a loss to determine the value of treatment. He wished to inquire whether this method of treatment caused the disappearance of those little fibrous nodules, or lessened their number.

DR. TUTTLE inquired how much pressure should be applied in bandaging the testicle.

DR. BREWER stated that he had not noticed the disappearance of the fibrous nodules referred to by Dr. Bryson. His cases were hospital patients and soon lost sight of. In reply to Dr. Tuttle's question, Dr. Brewer said that only a moderate amount of pressure was required.

On the Radical Cure of Urethral Stricture by Restoration of the Mucous Membrane to a Healthy Condition.—By DR. JOHN P. BRYSON, of St. Louis. Stricture of the urethra, Dr. Bryson said, is a chronic contracting peri-urethritis, caused by the leakage of urine or some of its constituents through a damaged or absent mucous membrane. This pathological definition enables us to accept a more definite and better classification of strictures, and appears more available than that of Vollmeier, which divides them into inflammatory and cicatricial, the first being still lined by mucous membrane, damaged though it be; the last by none at all, the mucosa having been replaced by cicatricial tissue. Any therapeutic procedure, therefore, Dr. Bryson stated, must primarily aim at a restoration of the mucous membrane to the normal state, and this is exactly what surgeons of to-day are doing in so many cases, with most flattering success. The author stated that his entire treatment of stricture

[1] Will appear in this JOURNAL.

was based on the theory that, if the mucosa could be restored to a normal condition while the stricture band was undergoing softening and inflammatory involution, a radical cure could be hoped for. Linear strictures, Dr. Bryson said, are often permanently benefited by the use of the sound only, but he considers this method entirely inadequate in the case of annular stricture. He then gave a history of a case of annular stricture which was treated by cutting and divulsion a number of times with only temporary relief, and which was radically cured by intermittent dilatation, combined with topical treatment directed to the restoration of the lining mucous membrane.

Treatment of Urethral Stricture.—By DR. L. BOLTON BANGS, of New York. Dr. Bangs defined stricture of the urethra as an unnatural narrowing of the urethral canal in any part of its entire length. That portion of the urethra described by anatomists as the bulbous portion is the largest in calibre, both in the adult and in infantile life, and is capable of the greatest amount of physiological distention. Dr. Bangs stated that he desired to reaffirm his belief in the principle formulated by Dr. Otis, namely, that the human urethra bears a proportionate relation to the size of the penis in which it is contained, and that this fact must be recognized in order to determine how to give radical and humane treatment for an infirmity which concerns so many. The treatment of strictures by divulsion, the author said, he considered both non-surgical and non-scientific. The effect of the instrument is distributed more or less beyond the strictured areas, and the resulting cicatrix is an irregular and ofttimes a violently contracting one. Electrolysis, also, he does not approve of. When a sufficiently strong current is employed to have any effect upon the tissues at all, it acts as an irritant and produces inflammatory deposits. Dr. Bangs regards gradual dilatation as sufficient for soft, non-fibrous strictures of the posterior urethra, or in the bulbous or penile portion, but for all strictures of large calibre requiring interference he advocates treatment by internal urethrotomy and complete division. If the stricture is of small calibre or be complicated by fistulæ either in the penile urethra or perineum, or if there be indurated cicatricial deposits posterior to four and one-half inches, he advocates, in connection with internal urethrotomy, an external perineal urethrotomy also, combined with prolonged perineal drainage.

The Treatment of Urethral Stricture and Its Resulting Conditions by Extreme Gradual Local Distention and Without Cutting; Including a Brief Resume of Fifty Cases.—DR. JAMES P. TUTTLE, of New York, read a paper with this title, in which he said that perhaps the best practical definition of stricture was that recently given by Dr. White in the words, "Stricture is an abnormal lessening of the calibre or the dilatability of the urethral canal, associated with changes in the mucous, muscular, or submucous structure constituting its walls." As to the question so frequently discussed, What are the normal constrictions of the urethra, and what relation do they bear to its normal calibre?—Dr. Tuttle said that he had made measurements of the dilated mucous membrane in fifty cadavers and in more than one hundred living subjects; these observations were made upon healthy urethræ, and in all cases certain constrictions and dilatations were found, all more or less uniform and no doubt perfectly normal. These he considers natural anatomical conformations, and they demand from the surgeon careful consideration and conservatism. The author said that he practised internal dilating urethrotomy for eight years, but that recently be abandoned the cutting pro-

cess in most cases and substituted treatment by extreme local distention—that is, at the strictured spot only. With this object in view, Dr. Tuttle has devised a new instrument, called a urethral dilator, which he has employed for some time, and with which he has obtained good results in these cases.

The three foregoing papers were discussed together.

DR. TAYLOR stated that the profession were apt to swing to extremes in the treatment of strictures. To Dr. Bangs, the speaker said, is largely due the credit of introducing perineal urethrotomy, which is a most admirable and beneficial procedure in certain cases, where there is a considerable amount of effused material, and where the stricture is deeply seated. In performing internal urethrotomy, Dr. Taylor said, he used a moderate-sized blade, and then practised gradual dilatation. The bladder and urethra were washed out with a solution of carbolic or boric acid before the operation; after the operation the bladder was again injected.

DR. PALMER agreed with the statement made by Dr. Taylor that surgeons run to extremes in the treatment of strictures. It is not long ago, he said, when everybody had the Otis instrument and used it indiscriminately, frequently doing more harm than good. His method of operating was similar to that of Dr. Taylor's. He did not consider it necessary to dilate the urethra up to its normal calibre at once, but preferred gradual dilatation. Perineal urethrotomy he considered an excellent procedure in some cases, but many patients in private practice will not submit to it and must be relieved.

DR. W. K. OTIS stated that an effort had been made in New York to bring out again the old operation of divulsion, which he considered utterly unscientific. In cases where the stricture was situated in the posterior urethra, and surrounded by hard, cicatricial deposits, it seemed useless to try to remove them by any but the surgical method of external urethrotomy. The speaker said that in his own work in dilating urethrotomy he has used Dr. Palmer's method of giving boric acid before and after the operation, with excellent results. He had not seen a urethral chill in some years, and considered Dr. Palmer's suggestion as a very valuable one to urethral surgery.

DR. FORDYCE said that he considered Dr. Bryson's definition of stricture —a chronic contracting peri-urethritis—as an excellent one, but that in his opinion stricture did not always depend upon an infiltration of urine.

He mentioned the fact that connective-tissue growth occurrs in the vagina and cervical canal as a result of gonorrhœal inflammation when the question of urine leakage could not be considered.

DR. CABOT stated that in the hospital with which he was connected in Boston a number of his associates practised the divulsion of strictures, with excellent results. He employed that treatment in one or two classes of patients, especially in the diaphragmatic form of stricture; a filiform bougie is first introduced, and then your divulsing wedge goes through and wipes out the stricture. Dr. Cabot said he considered the sweeping condemnation of divulsion as a mistake, and was probably due to the kind of instrument used. The Holt instrument is an imperfect one and hard to keep clean. The one devised by Dr. Bigelow, of Boston, is much better.

DR. BRYSON said that he did not think that the definitions of stricture, as given by Dr. Bangs and Dr. Tuttle, were broad enough. If we accept those definitions, we must begin at once to make exceptions, or else a narrow meatus, cancer of the urethra, or an enlarged prostate must be classed as strictures. His definition would obviate many of these conditions which re-

quire to be mentioned as exceptions to the rule. There is this difference between a congenital coarctation and a stricture: a stricture is not only narrower than the normal, but it continues to become so: there is a tendency toward slow but steady growth, whereas that is not the case with a congenital coarctation.

In regard to the etiology of strictures, Dr. Bryson said that contractions may exist in the cervix, or œsophagus, or the rectum. In strictures of the rectum you have some process going on, such as fecal leakage, which is the disturbing cause, instead of the urinary leakage we have in the urethra. Whether the original cause was a burn or traumatism or syphilis, you still have a peri-proctitis.

Treatment of Gonorrhœa.—By DR. W. FRANK GLENN, of Nashville. In his paper Dr. Glenn said that he has met with great success in the treatment of gonorrhœa by the use of mild solutions of chloride and iodide of zinc. The strength he usually employs is one-half grain of the chloride and one grain of the iodide to the ounce of water. This solution can be further diluted, if necessary, and is to be injected into the urethra three or four times daily.

DR. TAYLOR stated that the personal element entered very largely into the treatment of gonorrhœa, and a second person cannot always obtain such good results by following the same line of treatment. Chloride of zinc he considered very useful in some cases in the declining stages of urethritis, but he would be very loath to use it for deep injections. The iodide of zinc he has never used.

DR. WILLIAM JUDKINS, of Cincinnati, stated that he has met with considerable success in certain cases of urethritis by applying, by means of a sound, the yellow oxide of mercury, or introducing it into the urethra on a small piece of cotton.

DR. BANGS stated that he coincided with what Dr. Taylor had said about the personal element in gonorrhœa—not only of the physician, but of the patient also. The speaker said he was ready to welcome any remedy that would shorten the period of the disease.

DR. OTIS said that salol was recommended for gonorrhœa at last year's meeting. He had given the drug an exhaustive trial, and had seen nothing produced excepting a little dark-colored urine.

DR. PALMER said that he had met with the same experience.

DR. FORDYCE said that his experience with salol had been similar to that of Dr. Otis and Dr. Palmer.

DR. TUTTLE stated that he combined salol with the oil of sandalwood. Salol prevents the decomposition of the urine.

DR. GLENN exhibited a forceps which he has devised, and which he has found very useful in circumcisions.

The Association then adjourned.

Selections.

A Case of Severe Joint Affection Following Gonorrhœa. MAURIAC. (*Bullet. de la Soc. franç. de Dermat. et de Syph.*, 1890.)

The patient, a man aged twenty-six years, had acquired syphilis two years before. In January he had an acute gonorrhœa. On the sixteenth day after

its outbreak, sudden and severe pain occurred in the left shoulder and elbow. Five days afterward the entire arm was swollen to double its normal size, and the skin over the affected member red, the process having a phlegmonous character. High fever was present for a week. The acute symptoms passed off within fourteen days, but the joints remained painful. After two and a half months partial anchylosis of the affected joints and muscular atrophy of the left arm remained. The urethral discharge persisted during the rheumatic manifestation.

Concerning the Time and Cause of the Extension of Gonorrhœa to the Pars Posterior Urethræ. DR. IGNATZ HEISLER. (*Archiv für Dermatologie und Syphilis*, 1891, 5 Heft.)

After an examination of fifty cases of first infection of gonorrhœa, the author concludes—

1st. That posterior urethritis appears much earlier than is usually taught and accepted by the best writers.

His statistics show that in twenty per cent of the cases it appeared in the first week, in thirty-four per cent in the second week, and in fourteen per cent in the third week after the appearance of the discharge.

2d. Constitutional affections, especially syphilis, have little influence in hastening the occurrence of posterior urethritis, although the affection occurs more frequently in syphilitic subjects.

3d. Occupations which necessitate long-continued exertion play an important rôle in expediting affections of the deep urethra.

4th. The affection is equally prevalent whether injections are used or the treatment be confined to internal medication.

5th. The musculus compressor urethræ has no power to prevent the transference of the infective agent to the deep urethra.

6th. The gonorrhœal inflammation of the anterior urethra cannot be regarded as an affection of such typical course as is asserted by the majority of authors, *i.e.*, an inflammation starting in the fossa navicularis, reaching the bulb in three weeks; then, when the acme of intensity is attained, passing over to the posterior urethra. In the great majority of the cases, this happens during the first or second week without the direct transference of the gonorrhœal pus by means of catheters or sounds.

It must therefore be looked upon, not as a complication of anterior urethritis, but as a direct continuation of it.

The Therapeutic Effect of Diuretin. DR. GEISLER. (*Berliner Klinische Wochenschrift*, 1891, Nos. 15, 17.)

The writer comes to the following conclusions:

1. Diuretin increases the blood-pressure.

2d. It should be regarded not only as a diuretic, but also as a cardiac remedy.

3d. Its most striking effects are observed in disturbances of circulation brought about by valvular insufficiency.

4th. In affections of the heart muscle its diuretic effect is much weaker.

5th. In acute nephritis its diuretic action is much stronger than in chronic nephritis.

6th. In cirrhosis of the liver no diuretic action is observed.

7th. In the healthy individual the quantity of urine is somewhat increased.

PLATE I.

DR. TAYLOR'S CASE OF BROMIDE ERUPTION.

PLATE II.

DR. TAYLOR'S CASE OF ANNULAR TUBERCULAR SYPHILIDE.

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NOTES ON A BROMIDE ERUPTION AND ON ANNULAR TUBERCULAR SYPHILIDE.

By R. W. TAYLOR, M.D.

THE peculiar bromide eruption under consideration is not well known, and is only briefly described by several authors. The chief papers relating to it are by Cholmeley,[1] Horrocks[2] (two papers), Tay and MacKenzie,[3] Hutchinson,[4] Seguin,[5] and Szadek.[6] The case which forms the basis of this description occurred in the practice of my learned friend Prof. R. W. Amidon, who has kindly placed the photographs of it at my disposal. The initial stage of the bromide eruption under consideration is admirably well shown in the picture of the child's face. Under the right eye there are a few follicular pustules in an isolated state. On the upper right eyelid and corresponding temporal region is an encrusted elevated patch, and on the left side of the forehead is a similar patch. In these three groups we find a confluence of what appear to be acne papules and pustules.

[1] "Confluent Acne." Trans. Clinical Society of London, 1870, vol. 3, p. 38.

[2] "Bromide Rash." Trans. Pathological Society of London, 1883, vol. 34, p. 272 *et seq.*

[3] "Bromide of Potassium Eruption in a Child." Trans. of Pathological Society of London, 1884, vol. 35, p. 400.

[4] "Atlas of Skin Diseases." Sydenham Catalogue, Plate 43. London, 1875, p. 157 *et seq.*

[5] "On a Peculiar Cutaneous Lesion (Ulcus Elevatum) Occurring during the Use of Bromide of Potassium." Archives of Medicine, vol. 8, 1882, p. 149 *et seq.*

[6] "Zur Casuistik des Brom Exanthems." Vierteljahrs. für Derm. und Syphilis, 1888, p. 599 et seq.

The affection begins with follicular hyperæmia, and soon minute papules are formed. These increase in size and become pustular, the contained fluid being rather more inspissated than ordinary acne pus. In some cases but few of these lesions may be present, but in others they are very copious. They appear in crops, either rapidly or slowly, and as they grow more numerous they become fused together into a patch which at its acme is covered with a greenish-brown, uneven crust. Removal of this crust reveals a more or less papillomatous, even, mildly fungating surface, which is more or less elevated above the normal level of the skin. The extent and exuberance of the eruption depends largely upon the dose and the continuance of the bromide ing. sted. Thus we may have a sparse eruption, as seen in this case, on the face, or it may become more extensive and cover the cheeks and forehead, sometimes invading the scalp. In cases reported by Behrend, Cholmeley, and Grossman the whole body was involved. The eruption may remain on the face and head in an indolent incrusted condition, its salience becoming rather more pronounced. Then, again, in some cases of rapid or slow invasion the hyperplasia is so active and intense that very small elevated tumors are formed. I have seen these lesions from a quarter to half an inch in height. In this state the bromide rash resembles a rash caused by iodide of potassium, for which I humbly ventured to offer the name dermatitis tuberosa.[1] The iodide eruption is more liable to appear in scattered tubercles of round or oval outline having a diameter of from one-third of an inch to one inch and even more. The bromide tuberous eruption usually occupies more area, is more irregular and patchy in its outline, and may cover much more surface.

The bromide elevations, for which Seguin proposed the name ulcus elevatum, when seated about the face and head may remain in an encrusted state for a long time. Then, again, the crusts may dry and fall off, leaving a papillomatous surface. In some cases this uneven surface becomes smoothed off by attrition, and a large fleshy tumor is left. When this elevated lesion finally disappears, it may leave more or less scarring or the tissues may be left normal but temporarily pigmented.

The extent and character of this eruption upon the legs is well shown in the figures. There we have depicted a vast surface of ulceration covered with very adherent greenish-brown crusts. This eruption usually begins about the middle portion of the anterior surface of the legs, and from that focus it may, as it has in this case, extend to the back of the leg. Now, upon this region we find that this bromide

[1] "Dermatatis Tuberosa of Iodic Origin, the so-called Acne Anthracoïde Iodopotassique." N. Y. Med. Jour., Nov. 3d, 1888.

eruption begins in two ways. In the first and generally the more acute form, follicular papules scattered or more or less aggregated appear, and they soon become pustular, like their companions on the face. The eruption may develop slowly or quite rapidly. In either event the initial lesions grow, coalesce, and form incrusted, uneven surfaces. As these patches grow, they become more or less salient, but they rarely reach an elevation of more than one-quarter of an inch upon the legs. They show a tendency to linger in an aphlegmasic manner if the dose is made smaller or if the drug is discontinued. They may ulcerate, but rarely is the process very active or destructive. The outlines of the fully formed eruption is more or less irregular, and not infrequently we see patches of sound skin which have become surrounded by the bromide-eruption patches, as seen in the picture of the anterior aspect of the leg. When, either as the result of treatment or by their desiccation, the crusts are removed, we find a well-marked papillomatous surface, which may even approach a fungating condition. Under treatment, or owing to the cessation of the use of the drug, these lesions gradually wither and flatten down. When involution has thoroughly taken place, more or less uneven scarring is left, as well as a pigmentation which is very persistent.

The other mode of invasion of this eruption upon the legs is by the appearance of subcutaneous nodules of large or limited extent. The first appearance noticed is a slight redness of the skin, with perhaps some mild subjective symptoms. Palpation then reveals subcutaneous hyperplasia. Then to the eye the lesion looks like erythema nodosum in its chronic form. The nodules are somewhat salient, of a dull red color, and moderately painful or even insensitive. In this condition they may remain until their final retrocession. In other cases follicular lesions appear, and the eruption goes on to the production of the large fungating patches already described. Scientifically speaking, therefore, this eruption may be called a tuberous and fungating dermatitis due to the bromides.

The drawing which shows the back of a young man aged twenty-five, syphilitic two years, presents an admirable illustration of the annular form of the tubercular syphilide. This eruption was scattered over the face and the anterior surface of the trunk in as copious a manner as it was on the back. Though not exceedingly rare, this feature of the non-ulcerated tubercular syphilide is far from common. Usually this eruption shows itself in large or small scattered patches, which may be aggregated on some regions or it may form large, uniform plaques of infiltrated skin, accompanied by more or less decided epithelial hypertrophy. In this case, the lesions began as small tubercles scattered quite profusely over the trunk. These tubercles in-

creased in area, and, when about an inch in diameter, absorption took place in their centre, leaving a more or less atrophic patch contained within a well-marked morbid ring. From this time the lesion progressed in this ringed form very much as the serpiginous syphilide increases, though in the tubercular syphilide the morbid process is a specific hyperplastic one, while in the serpiginous syphilide the lesion is of an ulcerated character and undoubtedly largely due to microbic infection, in which a local infection occurs on the site of a general syphilitic infection. These large gyrate, annular patches, which were of a dull red, brown color, more or less scaly and in some places fissured, are seen to have involved much of the skin of the back. The rings inclose integument which is somewhat atrophic from interstitial absorption, and not as a result of ulceration. They are quite uniformly of a dull brown-red color and scattered over several are little accumulations of epidermal cells. As time went on, this pigmentation gradually disappeared from the centre to the periphery, until in the end a whitish, somewhat thinned skin was produced. This lesion is very apt to become chronic and indolent, to resist treatment unless it is very vigorous, and to recur from time to time upon new regions of the body. It may also occur on the extremities. In this case two large rings may be seen on the shoulders, showing a tendency to creep down the arm. The case, therefore, shows admirably the tubercular syphilide in its annular form, in which in a serpiginous manner it may creep over the whole body.

EPILATION: ITS RANGE OF USEFULNESS AS A DERMATO-THERAPEUTIC MEASURE.[1]

BY JOSEPH ZEISLER, M.D.,

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THE times in which we live demonstrate, more than ever before, the fact that medicine, unlike any of the exact sciences, is far from being a solid structure, but is in a constant process of evolution and revolution. The fundamental basis of our knowledge regarding most important pathological facts may be thoroughly shaken at almost any moment. And, viewed from a distance, our methods of treatment seem to change almost as rapidly as the pictures in a kaleidoscope. The number of new remedies, which spring up every day, is becoming legion, and only after years of observation the survival of

[1] Read before the American Dermatological Association, Washington, September 24th, 1891.

the fittest will show which of them has deserved the glowing praise bestowed upon each of them by its originator. Among the measures which have thus for a long period kept an apparently well-established place in dermato-therapeutics is the one to which I propose to devote the following notes; and, my object in doing so is based upon the fact that of late attempts have been made in different quarters to discredit that method, even in the management of such affections where for years it formed the alpha and omega of a rational treatment. Under such circumstances it is perhaps not quite superfluous to again point out the value of epilation as a curative agent for such diseases where it has heretofore been pretty well recognized, and to show, at the same time, its usefulness in the treatment of some other affections for which it has been employed but very little.

I have been unable to ascertain accurately how long ago epilation has been practised methodically in combating certain skin diseases. It seems, however, that only since Wertheim's[1] recommendation, some thirty years ago, it has become more generally accepted as a standard plan of treating sycosis.

In speaking here of epilation, I mean the systematic and methodical removal of hair in treating different affections of the hairy skin. For successfully performing this little operation a proper instrument is very essential; I always select an epilating forceps with narrow blades, which makes it easy to seize the individual hair shafts; the inside surfaces should be perfectly smooth and closely fit each other, the spring easily working. Observation has taught me that even this little operation requires a certain amount of skill and dexterity. I have seen beginners use the pincette in such a clumsy manner as to amount to hard work on the part of the operator and as to cause considerable discomfort to the patient. It is always desirable that the hair which is to be removed should be clipped short; this enables us to take hold much easier of each single hair, and to apply the instrument at the point where the hair shaft leaves its follicle. The removal of thick crusts adhering to the skin, by varying means, is always of service. Traction should be made in the direction in which the hair is implanted in the skin; this will necessitate an occasional change in the relative position of the patient to the operator. Good light is of importance. It is not desirable to remove single hairs at a distance from each other; but for practical reasons and for the purpose of good therapeutic effect, it is best to select a small diseased area, and to thoroughly clear it from all the hair on it; this makes it possible to operate speedily, and affords rest and support to the working hand. From time to time little pauses may be made, to relieve the patient, as well

[1] Zeitschrift der k.k. Gesellschaft d. Aerzte, Wien, 1861.

as the physician. Attention to these and some other minor details, which suggest themselves easily to any one who frequently practises epilation, will go far toward facilitating the sometimes laborious task and diminishing the unavoidable, though usually slight, discomfort on the part of the patient. With more than two hundred patients whom I have subjected to this procedure, I have never found any one to object to it on account of the severity of pain, or who after two or three treatments should not have become almost indifferent to it. A question which is almost invariably asked by patients, in the beginning of the treatment, is whether the hair would ever grow out again after removal "with the root." I usually answer them that we should hardly undertake as tedious an operation as the electrolytic destruction of hair from women's faces, should ordinary epilation suffice for its permanent removal. The epilated hair is usually regenerated after short time; I have frequently seen it to show up one to two weeks after removal. Only when deep phlegmonous processes or fungoid vegetations with undermining abscesses are present, a partial alopecia may result, not as a consequence of the operation, however, but of the destruction of numerous follicles. This the patient should better be told in the beginning of the treatment.

The advantages gained by methodical epilation consist in the removal of the several parasitic elements which may be imbedded in the hair shaft; second, in laying open the follicles, which now permit of a deeper reaching effect of any parasiticidal agent that may have to be used; next, in removing the hair, we do away with a source of irritation for the surrounding tissues; this is especially the case when the diameter of the hair is comparatively large, or where, as I have often observed on the scalp, several hairs are implanted very closely in the form of a tuft. Finally, we may remove, as a preventive measure, hair that is as yet unaffected, to save it from impending destruction by peripheral extension of a disease. These indications give to epilation a pretty wide range of usefulness.

Foremost among the affections in which epilation has for a long time been extensively used, must be mentioned ordinary sycosis, or, as I should be inclined to call it after Bockhart's[1] classical investigations, sycosis coccogenes. As I have mentioned above, Wertheim[2] deserves the credit of having pointed out its value over thirty years ago. This recommendation was based upon the idea that in sycosis the thickness of the hair root was out of proportion to its follicle, and that hereby the peri-follicular tissues had to suffer an undue pressure.

[1] Bockhart: "Aetiol. u. Therapie d. Impetigo, d. Furunkels u. d. Sykosis," Monatsh. f. prakt. Derm., 1887, pp. 450–471.

[2] Loc. cit.

I should not consider this a sufficient etiological element, but would look upon it only as a predisposing factor, while the exciting cause is given by the immigration into the follicle of those microbes which are now pretty generally considered to be the cause of suppuration everywhere. Only upon such an etiological ground can epilation be regarded as a sound principle of treatment; and if it is found successful, it lends a strong argument against the theory of the origin of sycosis by remote or diathetic causes. Quite independent, however, of the different etiological views, we find epilation given a prominent place in the management of sycosis by almost all standard authors, and it is recommended even by representatives of the theory of its constitutional origin, like Robinson,[1] Bulkley,[2] Jackson,[3] and others.

One of its earliest opponents was the late Auspitz,[4] who objected to it on the ground that it was a superfluous procedure, as the hair had anyway become loosened and was thus incapable of further mischief. This position seems to me quite untenable for several reasons, and its weakness may be easily seen by comparing, for the purpose of illustration, the diseased, thickly infiltrated hair with a foreign body, say, a splinter, which accidentally has entered the skin: shall we wait until free suppuration will eject the intruder; or is it not better policy to remove it as early as possible, to check suppuration? Within the last few years a crusade has been begun against epilation in sycosis by Unna,[5] and especially by O. Rosenthal,[6] who considers it as unnecessary, and claims good results by simple shaving and, as an essential part of the treatment, the application of a sulphur and tannin paste. Although I have found very few indorsements of the efficiency of this plan of treatment, I am willing, judging from the character of its upholders, to believe that it may in some cases be of value; but I am unwilling, as yet, to give up a plan of management by which I have invariably cured within reasonable time all cases of sycosis, fresh or inveterate, mild or severe, that have come under my observation. I do not know why epilation has not become very popular in this country: I judge such to be a fact from personal experience. It is surely quite a laborious undertaking in extensive cases; but the almost marvellous effect which follows its conscientious practice is more than gratifying. So thoroughly have I become convinced of its reliability that I should rather give up all adjuvant treatment by oint-

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[1] N. Y. Med. Journal, August, 1877.
[2] "Manual of Skin Dis."
[3] Journ. Cut. and G.-U. Dis., Jan., 1889.
[4] Viertelj. f. Derm. u. Syph., 1876.
[5] Monatshefte f. prakt. Dermatologie, March and April, 1889.
[6] Deutsche med. Wochenschrift, March 23d, 1889.

ments or lotions than to lose what I consider an indispensable instrument. But I give, of course, to salves, lotions, soaps, and regular shaving their proper place. I never prescribe, however, internal medicine of any description, as a matter of principle. I am well aware that even a most thorough epilation, while always followed by immediate improvement on the treated surface, will not be capable of preventing a relapse in some cases; this is especially noticeable when the affection occurs on the upper lip. For this fact we find an explanation in the chronic coryza, which almost regularly complicates or rather produces that trouble. But even in such obstinate cases a repetition of the procedure, regular shaving for a long period, and attention to the nasal trouble will finally be crowned by success.

Of the different localizations of sycosis other than the bearded face, two forms seem to me to deserve mentioning in this connection. The one, sycosis capillitii, is surely very rare. I have the notes of three such cases which had lasted from three to five years, respectively, before they came to my notice, and which had been treated rather unsuccessfully. In all of these cases the growth of hair in general was unusually copious, the individual hairs abnormally thick, and the peculiar tuft-like appearance of groups of hair referred to above was present in all of them. Notwithstanding the large area affected, I immediately resorted to methodical epilation as the main measure of treatment, and kept it up and repeated it over again until I found the extracted hairs to be of normal appearance. The good effect of this plan was very soon apparent; two of those cases were cured in from two to six months, and have remained well; the third, a woman who is still under observation, is gradually improving.

Another very rebellious form is sycosis vibrissarum. I have found very little about it in the literature of the subject. Hardaway, in a paper on "Inflammation of the Hair Follicles within the Nares,"[1] recommends in the first place proper internal treatment, and in especially severe cases the electrolytic destruction of the vibrissæ. He admits, therefore, the necessity of removing the hair; but while electrolysis would be a radical way to do it, it seems to me a very difficult operation to perform in that locality. I have always found repeated ordinary epilation to be quite effective in those cases.

In regard to the treatment of favus, there seems to be quite a consensus of opinion as to the absolute necessity of removing the diseased hair; authors differ only as to the best way to do it. The calotte has, perhaps, only a historical interest; but the method proposed by Bulkley[2] seems to me only a modification of it; lately, an Italian

[1] Jour. Cut. and Ven. Dis., March 12th, 1876.

[2] Arch. of Dermatology, April, 1881.

writer, Bertarelli,[1] recommended another revival or variation of it. He advises the use of a specially prepared pitch plaster, spread on narrow strips of linen, by means of which he claims to achieve the desired end without inflicting much pain. Kaposi's method is well known; he applies gentle traction by grasping a group of hair between the thumb and a flat spatula, held in the same hand, but removes only the loosened hair. Morrow, in an excellent paper on this subject,[2] criticises, very justly, all these methods, and gives to epilation its proper place. Piffard,[3] Hyde,[4] and others also recommend the epilating forceps. I fully agree with these authors. Epilation in favus is surely very tedious and not exactly pleasant for the operator; but it serves the purpose in view in a most reliable way, and I have not found it to be very painful. I have frequently been able to instruct the parents or a nurse, and sometimes even the patient himself, in the use of the forceps; and by thus pushing the work it is possible, even in excessive cases, to get the scalp free of diseased hair within a week or ten days. More than in any other parasitic trouble, is it important in treating favus to keep epilation up for a period sufficiently long to insure a healthy growth of hair, and the final success depends solely on the degree of persistency and energy with which the work is carried on. Mibelli[5] reported about two years ago some cases of favus in which he claimed a cure simply by shaving and the application of oleate of copper in the strength of 20%, but without resorting to epilation. I have found no further confirmation of his results, and should as yet be rather sceptical about the efficacy of his plan of treatment.

The general indications for epilation ought to make this procedure a standard form of treating tinea tonsurans; but the difficulty of employing it here successfully consists in the fact that the diseased hair usually is too brittle to stand the traction; the free shaft will break off and the infected root will remain in the follicle. It is therefore but natural that all sorts of treatment have been devised to destroy the fungus, without resorting to epilation. The idea to reach the deeper layers of the skin by making use of the cataphoretic action of the galvanic current as suggested by Reynolds[6] would seem, from a theoretical standpoint, to be very promising of good results. Reports on this method from the majority of authors who tried it have, however, been rather disappointing. Epilation, while not being capable

[1] Bertarelli: "Cura e Profilaxi della Tigna." Ref. in. Arch. f. D. u. S., 1861.
[2] Journ. Cut. and G.-U. Dis., 1886, p. 321.
[3] "Illust. Treat. of Skin Dis.," 1891.
[4] "Treatise on Skin Dis.," 1889.
[5] Ref. in Arch. f. Derm. u. Syph., 1889, p. 106.
[6] Journ. Am. Med. Asso., 1888.

of removing to a reliable degree all of the diseased hair, has, however, still a useful place in the management of tinea tonsurans; for, by removing, at least in fresh cases, the border hairs, we can arrest the progress of the trouble. In this sense epilation was recommended some ten years ago by Morris,[1] and later by Payne.[2]

Although caused by the same fungus, the clinical and therapeutical aspect of tinea sycosis is very different from the last-named affection; and, as a rule, the diseased hair may be abstracted without any difficulty—in fact, it is usually so loosely inserted in the follicle that its removal causes hardly any pain. Whatever I may have said as regards the importance of epilation in sycosis coccogenes might be repeated most emphatically with reference to sycosis hyphogenes.

I wish now to say a few words regarding the use of epilation in certain forms of pustular eczema, as I cannot remember ever having seen any reference to it. I have observed a number of cases which, in their clinical aspect, showed all the characteristics of an impetiginous eczema; but the pustules were mostly situated around and perforated by a hair; the surface affected was usually the back of hands and fingers or the extensor surface of the lower limbs. The obstinacy with which these cases had formerly resisted all attempts at treatment, even by competent men, led me to suppose that the hair might be a source of constant irritation, if not the seat of microbes. A few epilated hairs showed the exact appearance of the roots as is so regularly found in sycosis, and I then began to systematically remove all the hairs situated in the centre of those pustules. The benefit gained by this procedure was unmistakable. The peculiar condition of the hair led me to make the diagnosis of eczema sycosiforme. I could not class them with ordinary sycosis, because of the peculiar localization, and since other distinct features of eczema were present to a prominent degree. I am inclined to look upon the sycosiform condition of the hair as a secondary occurrence, brought about by the immigration of pus-cocci into the follicle. Without going into any clinical or pathological details of these cases, I wish here only to point out the great benefit derived from methodical epilation.

The last affection which I desire to mention in this connection is the one which originally prompted me to prepare these notes; namely, alopecia areata. During my visit last year to the Hôpital St.-Louis, in Paris, I was amazed to see in Professor Besnier's service the immense number of what is there called "pélades," and became especially interested in the peculiar treatment given them, consisting mainly in thorough epilation and the regular use of a sublimate lotion. I

[1] Lancet, 1881.

[2] Brit. Med. Jour., 1885.

determined to try the method, not only from a therapeutical standpoint, but believing that it might throw some light upon the question of the parasitic or neurotic origin of the disease. In studying the literature of the subject, I find that already in 1884 Ravogli[1] recommended among other measures epilation of the fine growth of hair on the affected patches. A year later a similar plan was suggested by Schulthess,[2] a believer in v. Sehlen's theory of the parasitic nature of the trouble. The treatment now in vogue in Paris was more prominently brought to notice in Feulard's work on the tineas, in 1886,[3] and again in Besnier's communication to the Academy of Medicine in 1888.[4] His plan is to clip the hair on the head or the beard and to thoroughly remove by careful epilation every hair on a small zone encircling each area. I have followed this method during the last year in about eight cases of alopecia areata. For different reasons I have given preference to the application of pyrogallic acid instead of the sublimate, which I employed only in the form of a soap. I do not intend to give a detailed history of those cases, but may sum up by stating that all those cases were cured in from six weeks to three months. I could clearly observe that in none of them would the disease spread beyond the epilated border, and in this sense especially would I look upon epilation as a very useful measure in alopecia areata. Whether the traction itself acts as an irritant or stimulant for the skin, I should not like to answer positively, but it seems not quite improbable. The results of the microscopic examination of area hairs by numerous investigators have furnished so meagre results that I should not dare to attribute any weight to my own observations in this respect. But I may say, at least, that even macroscopically the epilated hair showed such striking features—sometimes thickly infiltrated hair sheaths, sometimes a peculiar dry, dusty appearance—as to strongly suggest the idea that some parasite was imbedded in it. At any rate it seems to me that the good results of a merely local treatment, directed to destroy the cause, in the shape of some not fully established parasite, might be used as a strong argument for the fact that at least some of the causes of alopecia areata with which we meet are independent of tropho-neurotic disturbances, but are clearly of parasitic origin. I must resist, however, the temptation of entering here into a detailed discussion of that mooted question, for I did not mean to speak of the etiology of alopecia areata, but of the usefulness of epilation.

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[1] The Cincinnati Lancet and Clinic, June, 1884.
[2] Correspondenzbl. f. Schweizer Aerzte, xv., 1885.
[3] "Teignes et Teigneux," Paris, 1886.
[4] Ref. in Jour. Cut. and G.-U. Dis., January, 1889.

A BIT OF PERSONAL EXPERIENCE OF THE VALUE OF ARSENIC.[1]

BY L. DUNCAN BULKLEY, A.M., M.D.,
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I HAVE recently had such a striking personal experience in regard to the value of arsenic when properly administered that I am tempted to briefly present the facts, although I well recognize that some may object that but little can be learned from a single observation, and that on one's own person; but the results obtained on two occasions were so prompt and definite that there could be no possible doubt as to cause and effect, and they also confirm strongly what I have already[2] written on this subject. I am the more inclined to report these facts inasmuch as they illustrate a method of administration of arsenic in certain cases which does not seem to be thoroughly understood or accepted by the profession.

On about September 14th, just passed, I began to suffer with an irritation at the junction of the third and little fingers of each hand, which caused me considerable uneasiness, the itching and burning increasing quite rapidly. As I had had four similar attacks during the past two or three years, one of them being in the early part of this summer, I well understood the significance of the condition, and looked for considerable discomfort therefrom for several weeks; one of the attacks had lasted about five weeks in spite of varied treatment, various portions of the hands and fingers being affected more or less in succession.

In each of the attacks the process of development and the nature of the lesions were about the same. Beginning on the inter-digital spaces, generally first in those between the third and little fingers of each hand, fine vesicles formed, rather deeply, which often coalesced, producing large lesions, apparently multilocular. These became tense and hard, so that the fingers could not be brought together without much discomfort. Soon after the beginning of the eruption in the inter-digital spaces, fine, deep-seated vesicles formed on the backs of the fingers, toward the extremity; these could be felt as small solid masses before they appeared as vesicles, and the elevations were often apparent on looking at a finger sidewise, before they would be recognized from above. The itching in these deep-seated and newly forming vesicles was intense, and at the height of the eruption the suffering caused thereby could hardly be believed, except by one suf-

[1] Read before the New York Dermatological Society, September 29th, 1891.

[2] "On the Value of Frequently Repeated Doses of Arsenic in the Treatment of Bullous Diseases of the Skin," etc., New York Med. Jour., April, 1889.

fering from the same; the slightest giving way to the desire to scratch or rub the part resulted in spasm of general itching of the hands which rendered it almost impossible to refrain from violent friction; this, however, was always surely followed by new accessions of vesicles, and fresh suffering. When the attacks were at their height, there were always some few vesicles developed deep in the flexor surfaces of the fingers, but only near the palm, never on the distal phalanges; but the greater part of the eruption, outside of the inter-digital spaces, occurred on the backs of the last two phalanges of the first two fingers of each hand; the right hand was more severely affected than the left.

In the entire course of each attack the vesicles remained more or less distinct and separate, and were firm and persistent, and even when running somewhat together they never exhibited any patches or surfaces of exudation or moisture, nor appreciable thickening, as are ordinarily seen in eczema of the hands; on several occasions the surfaces between the fingers became torn, but the surface beneath dried up very shortly, with much the appearance seen in some of the forms of herpes, as distinguished from the exuding surface belonging to eczema.

During my former attacks I have resorted to various methods of treatment, and have never been thoroughly satisfied with the results, so difficult is it for one to prescribe for one's own maladies; never until this last attack have I been able to cut it short so promptly and satisfactorily.

On September 19th, there were masses of vesicles, more or less run together, in the last inter-digital spaces of each hand, extending nearly an inch up each finger, with some new ones forming deeply between the next two fingers; the hands felt hot and swollen, and the blisters between the fingers were tense and burning, with occasional paroxysms of itching; the previous night, sleep had been more or less broken by the irritation of the hands.

On this morning I began, at about eight o'clock, to take Fowler's solution, taking five drops, and repeating the dose in two hours, with considerable water; this treatment was kept up that day at doses of four or five drops about every two hours, and one dose was taken during the night following. After the second or third dose there was such a marked change in the feeling and appearance of the hands that I spoke of it to several friends: the itching had ceased, and the lesions, which before were full and tense, seemed flaccid and had lost much of their congested aspect. The same treatment was continued on the next day, with continued improvement; and on the third day, September 21st, it seemed as though the process was entirely checked, and I scarcely thought of the hands. I then neglected the drops, and took

none for several days, as I carelessly forgot the bottle when I went to Washington, to the Meeting of the American Dermatological Association.

On the 22d, my hands again gave me trouble, and crops of vesicles appeared on the backs of the fingers, so that within two days the back of the last phalanx of the right forefinger was entirely covered with grouped vesicles, confluent, and raising the epidermis pretty evenly, with very many lesions elsewhere on the other fingers. In order to demonstrate the matter to my satisfaction, I purposely refrained from arsenic for the next two days, but, at the suggestion of a friend, applied a ten-per-cent solution of ichthyol in water very assiduously every hour or two. This gave some relief to the burning, but failed entirely to check the production of vesicles, until, by September 25th, I was suffering about as much from my complaint as I was before I had first taken the arsenic.

I then began the drops on the morning of September 25th, taking five every two hours, freely diluted, and the relief was to me really marvellous: the itching ceased almost entirely after the second dose, and the vesicles dried up, so that by night I suffered no inconvenience. The drops were continued the next day, 26th, and by night of that day all the elevations had flattened down, and the process seemed at an end. I have taken no arsenic since Sunday morning, September 27th, and my hands have remained apparently well.

I have little to say regarding the nature of the eruption. That it was not a true eczema is, I think, evident from the clinical history, and the remarkable controlling power of arsenic, which has never in my hands produced such an effect in any eruption on the hands which I have called eczema.

Nor do I regard it as a dysidrosis—that is, as connected in any way with the sweat glands; for it has come at different times when sweating had nothing to do with it: this last attack began when the weather was cooler, and did not seem to be altered whether I was actively engaged and perspiring, as when at work in the country, or when quiet.

I regarded it as a neurosis, as the attacks have always come when I have been somewhat nervously exhausted by overwork, late hours, etc.; and on this last occasion I had a considerable amount of brachial neuralgia in connection with the eruption.

Whatever its nature, the controlling power of arsenic, when given in full and oft-repeated doses, was so striking that I have felt justified in giving this brief personal history, in the hope that others may be led to use this remedy more fearlessly when necessity seems to demand. I need hardly add that caution is of course necessary in ad-

ministering arsenic in these rather large and oft-repeated doses; but, as I have used it in many cases in the manner just described during the last ten years and more, as mentioned in the article already referred to, and without cause for regret in a single instance, I feel justified in again calling the attention of the profession to the subject here presented.

4 East 37th Street, New York.

AN OBSERVATION UPON THE TREATMENT OF EPIDIDYMITIS.

By SAMUEL ALEXANDER, M.A., M.D.,

Professor of Genito-urinary Surgery, Dermatology, and Syphilology in the Bellevue Hospital Medical College; Visiting Surgeon to Bellevue Hospital, etc.

I DESIRE to call attention to a single question respecting the treatment of epididymitis, viz., the effect of local medication of the posterior portion of the urethra during the course of the inflammation, especially when the latter is acute.

The treatment of epididymitis, unlike the treatment of urethritis, has remained comparatively fixed for more than a generation. Some form of antiphlogistic treatment has been employed in most cases, usually combined with or followed by compression. The form of the treatment and the mode of compression have varied with the taste and experience of the surgeon, but the principle of treatment has been the same.

Most writers upon the subject agree that when an epididymitis occurs during the course of an urethritis, all local treatment in the urethra is contra-indicated, especially if the inflammation is acute. Some recent writers, however, recognize the value of local medication of the posterior portion of the urethra after the acute symptoms have subsided. Dr. E. L. Keyes, in an article published in 1885 in the New York *Medical Record*, recognizes the value of instillations of the nitrate of silver into the prostatic portion of the urethra in cases of chronic relapsing epididymitis. E. Finger, in his work upon "Blennorrhœa of the Sexual Organs," mentions Diday's method of posterior urethral irrigation as a mild form of treatment in chronic cases, but he warns against the danger of using local treatment in the urethra too soon after the occurrence of epididymitis, and he holds that this form of treatment should not be used until all the acute symptoms of inflammation are gone from the epididymitis. This is the opinion usually held by the profession in general, although there are some surgeons who use local medication in the urethra when the epididymitis is subacute or chronic. It is certain, however, that local treatment of

the urethra in cases of acute epididymitis is not used to any great extent, if it is used at all.

Since 1884 I have used posterior urethral instillations of the nitrate of silver, and of other drugs, in the manner described by Dr. E. L. Keyes (a modification of Ultzmann's method), in subacute and chronic epididymitis, as well as in all inflammatory conditions of the posterior portion of the urethra.

More than two years ago I began to use this same mode of treatment in cases of acute epididymitis. From the first the effect of this treatment was so gratifying that I have used it since then in nearly every case of epididymitis which has come under my notice.

Since January last, I have treated more than forty cases of acute and subacute epididymitis by this method, either in private practice or in my service at Bellevue Hospital. Most of these cases were acute inflammations occurring during the course of true gonorrhœa. In all these cases the usual antiphlogistic applications were made to the testicle in addition to the local treatment in the urethra. The results have been very satisfactory.

There are certain points in the pathology of epididymitis as to which we have still only a very imperfect conception. But whatever theory may be held as to the cause of the disease, it must be admitted that it is always preceded by and associated with a posterior urethritis. It can also be established as a clinical fact that the intensity of epididymitis is in most cases, if not in all, regulated and controlled by the intensity of the urethral inflammation. The principal cause of relapse in an epididymitis seems to be an increase of the urethral inflammation. I have observed in a great many cases that any increase in the intensity of an epididymitis, or a recurrence of the disease, was always preceded by an increase in the posterior urethritis.

Most cases of epididymitis, when properly treated by rest and the application of heat locally to the testicle, run a simple course. But there is always a tendency to relapse from causes seeming slight unless the utmost care is taken to prevent it. It is this tendency to relapse so characteristic of epididymitis that makes rest in bed, until nearly all pain and tenderness have gone, absolutely necessary in nearly all cases of acute inflammation of the testicle, as they are treated usually. It is to prevent relapse by controlling the inflammation at its source, viz., in the posterior portion of the urethra, that the nitrate of silver instillations are used, although in some cases this treatment also seems to shorten the duration of the disease.

The value of the nitrate-of-silver instillations is recognized by all who are familiar with their use, and have tested their value in acute posterior urethritis and urethro-cystitis; and I believe that I

have tested this mode of treatment in a sufficient number of cases of acute epididymitis to say that the results obtained when the latter condition is present are equally satisfactory, and that inflammation of the epididymitis, even when acute, does not contra-indicate the careful use of this treatment.

It is possible, by the use of the nitrate-of-silver instillations, to treat the urethral inflammation during the existence of an epididymitis, and so to avoid the delay which usually is necessary.

I have always used and greatly prefer Dr. Keyes' modification of Ultzmann's instrument.

If, upon the first indication of the extension of an urethritis into the posterior urethra, deep urethral instillations of the nitrate of silver are begun, epididymitis often will be prevented. As I have stated in a previous article published in the August issue of this JOURNAL, I examine nearly every day the morning urine, of all patients under my care who have urethritis, by the "two glasses test," and begin deep urethral instillations upon the first appearance of pus in the urine of the second glass. I believe, as the result of careful observation in a number of cases, that epididymitis rarely, if ever, occurs simultaneously with posterior urethritis, and that, when it seems to do so, the first symptoms of the latter have been overlooked.

The use of deep urethral instillations of the nitrate of silver in acute and subacute epididymitis does not differ very much from their use in acute and subacute uncomplicated posterior urethritis.

As the use of the nitrate-of-silver instillations in acute epididymitis has not been described previously, as far as I know, I shall give very briefly an outline of the method of treatment followed in the forty cases upon which the observations contained in this paper are based.

Upon the onset of acute epididymitis, or as soon thereafter as possible, the patient should be put to bed, the lower bowel emptied by enema, and the necessary examination made of the prostate, vas deferens, testicle, urine, etc. The testicle should be supported and poulticed with flaxseed. If the pain is severe, a hypodermic of morphia should be given. When this has been done, the first application of the nitrate of silver may be given.

If the inflammation is very acute, or if the patient is hyperæsthetic, I begin by giving a tentative injection of about gr. i. to the ounce. The first injection should never be stronger than three grains to the ounce, and not more than fifteen minims of the fluid should be injected. The point of the catheter-syringe should be introduced just within the membranous urethra.

The instillation should be made soon after the patient has passed water, so that there may be as little secretion in the urethra as possible.

The effect of the injection is to cause an increased desire to pass water and a sensation of burning in the perineum. This disappears almost entirely after the patient has passed water, unless the injection has been too strong or unless the patient is very sensitive. The instillation is repeated in twenty-four or forty-eight hours according to the effect produced by the first. When a weak injection has been given to begin the treatment and does not cause pain, the second should follow in twenty-four hours. From three to eight grains to the ounce of the nitrate of silver is usually as strong as it is necessary to use in *acute* epididymitis. I prefer to give frequent injections and to give them weak, rather than to give strong injections at longer intervals. After the acute symptoms of the epididymitis have subsided, it may be necessary to increase the strength of the injections to cure the urethritis. In acute cases of epididymitis it is necessary in most cases to keep the patient in bed for from three to four days, often for one week. As soon as the testicle can be handled without causing a great deal of pain, I replace the poultice of flaxseed with a thick layer of cotton, covered by rubber tissue, and make even but gentle pressure by means of a gauze finger bandage, taking care to first firmly compress the cord by strapping.

These injections I use in all cases of epididymitis, no matter how acute the inflammation, and I am satisfied that the method is one of great value in *acute* and *subacute* epididymitis, as well as when the disease is chronic.

My observations do not as yet warrant me in claiming that this form of local treatment shortens the duration of the disease, although in some cases it seems to do so: but the great advantage of the treatment is, as I have said, that it overcomes the tendency to relapse so characteristic of epididymitis. As soon as the pain has subsided so that the patient can walk without much discomfort, he may go about, provided that the testicle is properly supported. In the forty cases that I have mentioned, relapse occurred in only two; and in several who had previously suffered with epididymitis, the known tendency to relapse which had existed during these former attacks was entirely overcome by instillations.

Another advantage of this form of treatment is that the duration of the accompanying urethritis can be shortened, because treatment of the posterior urethra is continued during the existence of the epididymitis.

During the course of an acute epididymitis, the inflammation of the anterior portion of the urethra is greatly modified, and, as a rule, this portion of the urethra does not call for active local treatment. I have usually stopped, therefore, all local treatment in the anterior

urethra in cases of acute epididymitis, until the posterior urethritis has been controlled.

In conclusion, I desire to say that I was first led to use this form of local treatment in the urethra, in the treatment of *acute* epididymitis, by the effect produced by the instillations of the nitrate of silver in cases of uncomplicated acute posterior urethritis and urethro-cystitis.

At the time of writing this paper, I had failed to find that this form of treatment had been described previously in acute epididymitis. Dr. R. W. Taylor has called my attention to the mention, in his work upon "Venereal Diseases," of a verbal communication by Dr. Boeck, of Christiania. The latter does not describe his method in detail, but states that he injects a few drops of a solution of the nitrate of silver into the prostatic urethra in acute epididymitis, and that, unless there was much fluid in the cavity of the tunica vaginalis, this treatment cured the disease in three or four days.

95 Park Avenue.

NOTE RELATIVE TO PEMPHIGUS VEGETANS.

By JAMES NEVINS HYDE, A.M., M.D.,
Chicago, Ill.

Concluded from page 421.

On the 10th of May I removed, with strictest antiseptic precautions, a few drops of the unopened chamber of two bullæ by the aid of a Koch syringe, and submitted the fluid to the Laboratory of the Alumni Association, College of Physicians and Surgeons, New York, with the result of receiving in return the following report as to the bacteriological examination there made by Dr. T. M. Cheeseman:

"The vial contained fluid from a bulla, in a case of pemphigus vegetans, for bacterial examination. The cultures have since been under observation, with the result of isolating a bacillus and a coccus: neither show any very characteristic appearances.

"The *coccus* is medium in size, occurs singly and in twos, is non-liquefying in gelatin, produces no color, grows actively at room temperature and in the air.

"In *gelatin plates* the colonies appear as white spots to the naked eye; low powers show them to be yellowish and more or less circular, secondary colonies forming on the edge and extending beyond it. Increasing in size, they become irregularly fissured on the periphery, the fissures extending inward for a greater or less depth. The surface colonies have sharply defined edges, are deeply fissured, and the older

colonies show a spreading growth paler in color, tesselated in appearance, and sharply defined. All colonies are granular.

"*Broth* becomes cloudy, and both a scum and precipitate form.

"*Gelatin tubes* show moderate growth in puncture line, the surface growth is spreading, covering the whole surface and irregular in outline.

"*Agar.*—*Streaks* show active growth, slightly spreading, irregular in outline, and with saw-edge.

"*Punctures* show considerable growth.

"*Potatoes* show active brownish growth, spreading slightly; on drying, small tubercle-like spots appear on the surface.

"The *bacillus* is short and of medium thickness, having a length of 2×1 μ or less (in diameters); it grows rapidly, forming threads which divide into bacilli. Involution forms are found on second day. It is non-liquefying in gelatin, produces no color, has no intrinsic motility, grows actively at room temperature, also at 37.5° C. No spore formation observed.

"In *gelatin plates* colonies appear to the naked eye as white points, low powers show a loose, irregular, felt-like mass, grayish in color, which become yellowish in the centre as growth progresses. The yellow portion is opaque and increases rapidly in diameter, the edge or peripheral zone retaining its felt-like gray appearance. Surface growths retain characters of the deep, but become surrounded with a grayish, wavy, tress-like zone, with sharply defined edge.

"*Broth* clouds and forms scum and deposit.

"*Gelatin tubes* show growth in puncture line; on the surface the growth is flat, spreading, and of irregular outline.

"*Agar.*—*Streak* growth is colorless to naked eye; low powers show a yellowish color, shading to gray on the edge, where the bacilli and threads may be easily made out, extending beyond the edge of the colony. After some days the growth becomes abundant and irregular on the edge.

"*Puncture* shows abundant colorless growth.

"*Potatoes.*—Active brownish growth along the streak, spreading slightly.

JUNE 26TH, 1891."

REMARKS.

The history of the disorder to which the name "pemphigus vegetans" was given by Neumann, in the year 1886 ("Vierteljahrsht. f. Derm. u. Syph.," Vol. XIII.), was admirably and fully set forth, in the year 1890, by Dr. Crocker, whose monograph on the subject has been already cited in these pages. Kohn, Auspitz, Riehl, and Hutchinson,

with the two authors named, had at that date furnished the records of sixteen cases which were tabulated by Crocker, with details, as far as these could be ascertained, as to sex, age, symptoms, duration, post-mortem appearances, etc. In fourteen cases, the two sexes were equally represented; the ages were from twenty-four to fifty-eight years. Of twelve cases, in eight the disease began in the mouth; in four, in the skin; but, in ten at least, there was a history, at one time or another, of mouth lesions. Two were pregnant when attacked. Excluding the first recorded case, in which there was an attack lasting three years and, in six years after, a second and fatal attack lasting thirteen months, all the cases recorded terminated fatally in from six weeks to fourteen months, with insignificant secondary post-mortem changes discoverable.

Since the date of these cases reviewed by Crocker, Kaposi has made a report on the subject before the Vienna Dermatological Society, during his presidency, on the 10th of March, 1890. He at that time exhibited drawings of the portrait presented by the first of the patients on record, that to which reference is made above and described by him under the name of Kohn, in the year 1869. He also reported his second case, that of a woman thirty-four years old, with two daughters of the same family similarly affected. As usual, the disease began in the mouth with the occurrence of aphthæ; then came nodules in the genital region; lastly bullæ over the belly, thighs, and axillæ. There was an intense febrile movement, deep brown, framboesiform, softish proliferations, projecting half a centimetre above the level of the adjacent skin, and readily bleeding. Large, disseminated bullæ appeared in the vicinity of these patches. The general condition of the patient was highly unfavorable; and a grave prognosis was formulated.

In the discussion that followed, Hans Hebra took occasion to remark that, in his judgment, pemphigus vegetans was not a special form of pemphigus, as vegetations occurred in different varieties of that disease. In September of the same year, at the reunion of German physicians and surgeons at Bremen, in the Section of Dermatology and Syphilis, Müller, of Hamburg, reported the results of his study of twenty-four cases, the number probably including some of those given in Crocker's tables. Of the entire number, the author regarded six only as of pure type, the others to be only assigned hypothetically to the category of the disease.

He recognizes two stages of the affection: one, the erysipelato-bullous; the other, a condylomatous. He believes the characterstic phenomena to be epithelial proliferation and connective-tissue growth, analogous to that observed by Pollitzer in akanthosis nigricans; also

immigration of migratory cellules into the epiderm, and foci in the centre of small cells not fibrinated (dry abscess). In addition there is the usual dilatation of lymph- and blood-vessels and of the mouths of the sweat glands, but probably no involvement of the orifices of the follicles. He would, with Unna, name the disease "vegetating bullous erythema."

One is surely not justified in venturing upon dogmatic assertions respecting a malady which he has observed but in a single case. As the patient whose history is given above is, however, as far as I am aware, the first to suffer from pemphigus vegetans whose case has been recorded in this country, Crocker's being, in the year 1890, the first-recognized instance of the disease in England, it may be pardonable if I conclude by touching very briefly upon one or two points suggested by this single experience.

The name proposed by Unna for this malady, "vegetating bullous erythema," should, it seems to me, be rejected, because: (1) to Neumann is distinctly due the credit of first clearly recognizing the disease, and then giving it the name which in his judgment seemed most fit; (2) the occurrence of bullæ, of vegetations, and of erythema, is far from rounding out the complete pathological cycle of the disorder, many other processes of importance pathologically coming under observation during the evolution of the disease; and (3) because the chief name, in the new title suggested, indicates the most transitory of all its features.

Respecting, further, Hans Hebra's comment upon Kaposi's report, that pemphigus vegetans is not a special form of pemphigus because vegetations occur in several varieties of pemphigus, this is a species of reasoning that cannot be safely trusted in scientific investigation. Because pustules are followed by cicatrices in both syphilis and variola, it by no means follows that the two diseases are one. Certainly herpes zoster is not more distinct from herpes simplex, and erythema multiforme not more removed from erythema intertrigo, than is pemphigus foliaceus or pemphigus neonatorum from pemphigus vegetans. There are indeed few disorders of any class (rare of occurrence and exhibiting clinical pictures that are only to be appreciated from scanty descriptions in different languages, and these produced originally in widely separated countries) where, as in pemphigus vegetans, there is such a striking unanimity as to the characteristic features of the disease whenever it falls under the observation of medical men. One can indeed, from written descriptions alone, almost accept or reject the published report of a case. How striking the fact that, up to the present date, almost every patient, from the date of the first seen by Kohn, has at the outset been supposed to be suffering from syphilis.

That I personally did not fall into this error in the present instance is due probably to the fact that I had so lately listened to Neumann on the subject, in Paris, where he exhibited his plates of the disease. The very fact, I repeat, of this consensus of errors, points to a remarkable unity in the early expression of the disease in every case. This is certainly not true of any form of pemphigus besides that under consideration. Pemphigus vegetans is shown, in fact, by these records, to be a disorder unique in its symptoms and course, describing with rare precision and insignificant variations a line of progression whose terminal points can be fixed with reasonable accuracy.

Though the several features of this disease point unmistakably to a morbid condition of the nervous centres, it must be admitted that at present we are ignorant both as to its cause and nature. The discovery of even unknown bacteria in an unruptured bleb, or a recognition, during the production of the latter, of characteristic behavior of epithelium, would not greatly aid in the solution of its serious problems. We are therefore, in the present state of our knowledge, not justified in giving the disorder, on any pathological basis, a novel name. If it were to be identified by one of its most striking physical peculiarities, it would not be important to emphasize the condyloma-form picture it presents in the early part of its career, since this is more or less rapidly lost in the series of remarkable changes which follow. Rather would it be necessary to recognize the constant tendency of the exanthem to limit its patches within defined borders. If it be proper to name eczema marginatum for such a reason, certainly pemphigus vegetans is a pemphigus marginatus. This is a feature more or less faithfully preserved throughout its course, the few exceptions being apparent only when the bullous efflorescence is seen on the hands and feet.

As to the individual case made the subject of this paper, its several features are apparently mere reproductions of those portrayed by other observers in recorded cases. It is true that, in the present case, there is promise of convalescence after more than six months of disease. But this apparent difference is to be explained probably by the circumstance that my patient was one treated, not in hospital, but in private life, where she was able to command the comforts and many of the luxuries of a home with exceptionally good hygienic surroundings. A severe recurrence of all the symptoms during the next twelvemonth, and even a fatal issue in that time, would only bring the history of the case within the grave category of some that have been already placed on record.

Society Transactions.

THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY.

Thursday Evening, October 8th, at 8:15 P.M.

An Observation upon the Treatment of Epididymitis.[1]—By DR. SAMUEL ALEXANDER.

Discussion.

DR. BANGS thought the author had been a little too general in his claims when he declared that surgeons do not recommend instillations of silver nitrate or any other applications to the urethra during the acute stage of the epididymitis. It has not been his practice to intermit treatment, and he believed that the urethritis is shortened and the process of repair hastened if treatment is continued during the acute stage of the epididymitis. This principle Dr. Bangs both taught and practised constantly. The speaker inquired whether, in Dr. Alexander's opinion, the duration of the epididymitis was shortened by the instillations of silver nitrate.

DR. ALEXANDER stated that he did not have with him the records which he had prepared, but that there was no marked diminution in the duration of the acute symptoms. The average duration of the acute symptoms was six or seven days. The point which he desired to bring out in his paper was the prevention of relapses after the patient got out of bed.

DR. BANGS said that this was the answer he expected, and it was entirely in accord with our pathological knowledge of the inflammation. He had often made the statement that "four days in bed," to use a humorous expression, was the best treatment during the acute stage of epididymitis, aided perhaps by minute injections of morphia in sensitive persons—especially lawyers. The speaker said he could recall case after case where a brilliant result had been obtained in posterior urethritis by the application of silver nitrate. As to the relapses occurring in epididymitis, they are troublesome to the surgeon and most disappointing to the patient, and due, perhaps, to a personal condition. A full, heavy man, with the gouty disposition, is very apt to suffer from relapsing epididymitis. Whether the gonococci are held in suspense, or surrounded by a productive inflammatory process, he did not know, but he has often observed that some of these individuals, after getting up and resuming their occupations, are tormented and alarmed by a hyperæmia of the testicle, with fulness and pain, and sometimes an outbreak. In such cases he has found the posterior applications of silver nitrate very valuable. In one case that had come under his observation, however, the epididymitis was aggravated by the applications, and the patient did not recover until an absolute change in the treatment was made.

Inflammation of the epididymis, Dr. Bangs said, is a pathological process, and it will take just so much time for nature to repair the damage. He thought "four days in bed" was about the best thing to do. He agreed with Dr. Alexander as to heat being the best application: whether it be

[1] See page 455.

applied in the form of a dry poultice, as suggested by Dr. Brewer, or by any other method, it is the heat and moisture which relaxes the tissues and relieves the pressure upon the peripheral nerves, and perhaps in some way stimulates the capillaries.

DR. ARMSTRONG stated that he did not agree with what Dr. Alexander had said about continuing the urethral injections during the acute stage of the epididymitis. It has been his rule almost invariably to withhold the injections during that period, and he has observed that the symptoms of the urethritis almost cease entirely during the active stage of the inflammation. He therefore saw nothing to be gained by making injections at that time. Of course, after the active symptoms of the epididymitis have passed off, it is well enough to begin your urethral disinfection again. As evidenced by the lesser amount of discharge, the speaker though that during the active stage of inflammation there was a depletion of the blood-vessels of the urethra.

As to external applications, Dr. Armstrong said he never used the hot applications, as they produced a vascular paresis, and he considered them injurious.

DR. BREWER stated that he did not know that an epididymitis meant a direct continuity of infection. Cases are quite common where an epididymitis will suddenly light up without any symptoms of deep urethritis, although it is possible that such a urethritis may exist without pronounced symptoms. He considered the suggestion made in Dr. Alexander's paper—namely, to allow the urine to pass in two bottles and examine the second specimen for pus—as a very valuable one. Theoretically, it is very well to say that epididymitis is caused by deep urethritis, but clinically we cannot always trace it to that source. If an attack of epididymitis could be aborted by local applications, it would be a great gain, but the speaker thought that, after the inflammation has once become established, local applications will not make much difference. In regard to more chronic cases, where relapses occur, and which are no doubt due to posterior urethritis—in such cases he has met with great success in the use of local applications. As to the treatment of anterior urethritis, Dr. Brewer said it has always been considered a bad plan to continue the injections while the epididymis was acutely inflamed, but he saw no special reason for this, as injections made in the ordinary way are not likely to reach the posterior urethra.

DR. BANGS, in reply to a remark made by Dr. Brewer, said he thought there were several things that bore us out in our belief that epididymitis is caused by an extension of the inflammation in posterior urethritis. In every case of epididymitis or other complaint with regard to the testicle coming under his observation, it is his custom to explore the vas deferens—both externally and per rectum—and he has always found a fulness on that side of the prostate and of the vas deferens, as far as he can make out. Besides that, we know that epididymitis does follow a posterior urethritis. Dr. Bangs then gave the history of a man who apparently had an irreducible hernia; upon more careful examination it was found to be an undescended testicle, associated with hernia. Upon operation, an inflamed testicle was found, together with a congenital hernia. A radical operation was done for the hernia. The testis was adherent and the cord large and swollen. The cord was drawn down and outward and, after being secured, it was severed, when there was a profuse discharge of pus. This pus was unfortunately lost, and it was impossible to investigate the interesting question whether or not

it contained gonococci. It was afterward learned, upon inquiry, that the person had an antecedent urethritis.

DR. TAYLOR stated that while he did not wish to detract from the honor of either Dr. Alexander or Dr. Keyes, he desired to say that as far back as 1868 he had been in the habit of making instillations of nitrate of silver during an attack of epididymitis. Both Dr. Otis and Dr. Bumstead followed that practice, and it was taught by them to the students of the College of Physicians and Surgeons.

In reply to Dr. Brewer's remarks, DR. TAYLOR stated that posterior urethritis probably existed more frequently than we thought, and that the symptoms are often not accentuated. As to injections during the acute stage of the epididymitis, the speaker said that these patients did not like to be tampered with, and he thought it was a good plan to let them alone. We can never prognosticate as to the course of an epididymitis; it is very erratic. Some cases do well with pulsatilla or gelsemium. In some cases heat acts better than cold, and *vice versa*. The lead and opium wash is beneficial, and there are cases where the old tobacco poultice will give more comfort than anything else. Others paint the parts with a silver-nitrate solution, or use iodoform. A plaster made of powdered opium and starch and glycerin often works very well; it seems to draw the serum out of the testicle. Above all things, it is well for the patient to follow Dr. Bangs' suggestion, and spend four days in bed.

DR. ALEXANDER said the only object of his paper had been to bring this question of posterior medication up for discussion. In regard to the existence of posterior urethritis when an epididymitis exists, he wished to say that he had tested all the cases at Bellevue, and found that, whenever an epididymitis was present, there was also posterior urethritis. He considered the question raised by Dr. Bangs, with regard to an extension of the inflammation to the vas deferens, as a very interesting one. The cause of epididymitis is still very much in doubt. Often it is caused by gonorrhœal infection, but we see cases of epididymitis in old men caused by the passage of a catheter.

A Contribution to the Study of Cystic Tuberculosis.[1]—By DR. L. BOLTON BANGS.

Discussion.

DR. CURTIS stated that not long ago an interesting case of bladder trouble had come under his observation. The man was about thirty years of age, and gave the history of an antecedent gonorrhœa. He had been in bed for some months and the bladder had been treated by irrigation. When Dr. Curtis first saw him the man complained of constant pain in the bladder, and urinated every ten minutes. A very slight amount of pus was discovered in the urine. The prostate was tender, but no changes in it could be made out, excepting one or two small nodules. The man was first treated by irrigation, and then by perineal drainage. He improved slightly under the latter treatment, and as long as the tube was in he felt quite comfortable. But the pain and spasm afterward returned, the perineal wound closed, and the man left the hospital in about the same condition he was in when he entered it. Still, there was no evidence of tuberculosis in this case, more than the symptoms of irritable bladder.

[1] Will be published in this JOURNAL.

DR. ALEXANDER said that in the few cases of tuberculosis of the bladder that he had seen operated upon, the supra-pubic drainage was employed, which Bangs says is the only form that gives any relief. Dr. Alexander then gave the following history of a case coming under his observation: The patient had la grippe eighteen months ago; about six months afterward he had great difficulty in passing water. His morning urine contained a few shreds, which, upon examination, revealed the tubercle bacilli. The prostate was hard, and on the left side of it was a nodule which could be faintly felt through the rectum. A urethroscopic examination showed over this nodule an eroded surface, which bled easily and had a grayish appearance in the centre. This spot was cauterized with solution of silver nitrate, applied direct to the ulcer. The patient had considerable tenesmus following this, lasting for forty-eight hours, and then felt much relieved. Since then five similar applications have been made, three with the deep urethral syringe and two through the urethroscope. They seem to have relieved him greatly; during the past three or four days he has passed his water about every three hours. He still has slight tenesmus. The man had consolidation of the entire right lung, and the shreds in his urine constantly contained tubercle bacilli. Dr. Alexander said that he had seen this case in consultation with Dr. Loomis. When the question of operation came up, he was in favor of operating if no relief was obtained by the above method. He would like to get Dr. Bangs' experience in the local treatment of these cases.

DR. BANGS had seen many cases where topical applications were made, but he could never detect such positive evidence in the urethra itself. Since using the cystoscope, he has been able to discover evidences of inflammation in the badder, but he has never discovered a tuberculous ulcer in the posterior urethra. With regard to the application of silver nitrate when the disease is located in the prostate, he has found that such applications aggravated it, and Dr. Keyes once informed him that in his opinion this very aggravation went to show that the lesion was tubercular.

THE AMERICAN ASSOCIATION OF DERMATOLOGY.

FIFTEENTH ANNUAL MEETING.

Held at Washington, D. C., Sept. 22d–25th, 1891.

FIRST DAY.

The meeting was formally opened by the address of the president, Dr. F. B. Greenough, of Boston.

The report of the Committee on Nomenclature was read and discussed.

Dermatitis Hæmostatica.[1]—By DR. HERMAN KLOTZ, of New York.

Discussion.

DR. BRONSON, of New York, stated that it is a well-known fact that ulceration sometimes supervenes in an eczematous surface. The pathological process in eczema should be clearly distinguished from that in ulceration. Eczema by itself never ulcerates: some other factor must intervene or super-

[1] Page 361.

vene to produce an ulceration. This secondary process is due to vascular engorgement and stasis. The term dermatitis hæmostatica does not precisely express the condition in the affections under consideration. It is neither exactly hyperæmia nor hæmostasis, but a combination of both. The circulation is not merely arrested, but there is a damming up and an accumulation of the fluid. Moreover, engorgement may exist without complete stasis. Of the existence of certain groups of skin diseases differing from ordinary inflammations or dermatitides due to this condition, the speaker said, he was fully convinced.

DR. KLOTZ, of New York, said he was not entirely satisfied with the name, but could find none that would better signify the character of the disease.

DR. PIFFARD suggested the name perstans.

DR. KLOTZ said that name would not indicate the connection of the disease with the circulation, or the part performed by the blood-vessels.

Report of a Case of Universal Erythema Multiforme, with Colored Portraits and Specimen.[1]—By DR. L. A. DUHRING, of Philadelphia.

Discussion.

DR. SAMUEL SHERWELL, of Brooklyn, stated that he had recently seen a case of general erythema multiforme of which the picture and history just given forcibly reminded him. The mucous membranes also suffered. The patient recovered promptly without exfoliation or any of the bullous lesions of the case under consideration.

DR. SHEPHERD, of Montreal, said he would like to inquire what previous treatment the patient had undergone for his rheumatism before the eruption appeared. The question arose in his mind whether the treatment had anything to do with the occurrence of the eruption.

DR. DUHRING stated that the patient had not received any treatment, as the diagnosis was obscure when he came under his observation. The *malaise*, nausea, and prostration, together with the eruption, were confusing to the medical gentlemen in charge, but the supposition that the disease might have been produced by previous treatment could be excluded.

DR. FOX, of New York, stated that Dr. Shepherd's question suggested a case that had recently come under his observation. The patient had been treated for gonorrhœa. He could not assume that the eruption was produced by copaiba, because it presented exactly the same appearance as when it occurs from ordinary causes. There may be a combination of two diseases, as sometimes occurs in psoriasis, when the eruption gradually assumes the character of dermatitis exfoliativa. There is no line of demarcation between the two affections.

An Unusual Case of Sarcoma, Involving the Skin of the Arm: Amputation: Relapse.[2]—By DR. F. J. SHEPHERD, of Montreal.

Multiple Sarcomata. History of a Case Showing Modification and Amelioration of Symptoms with Large Doses of Arsenic.—By DR. SAMUEL SHERWELL, of Brooklyn.

(These two papers were discussed together.)

DR. ZEISLER, of Chicago, stated that he wished to say a few words in regard to the splendid effect of arsenic in a case of lympho-sarcoma which he had under observation for over three years. There were present exten-

[1] Page 421. [2] Will be published in this JOURNAL.

sive tumors around the neck and in the axilla and inguinal regions. The patient was placed on Fowler's solution, and the drug pushed to the point of tolerance. Three months later the tumors had considerably diminished in size. Within the last two years the patient had a relapse on two occasions, which always yielded to the renewed use of arsenic. In a case of multiple pigmented sarcoma, the same treatment failed to prevent a fatal termination.

DR. WHITE, of Boston, said he wished to refer to a case treated several years ago in the Massachusetts Hospital, under charge of Dr. Shattuck, in which there were many cutaneous tumors. They disappeared under the influence of arsenic, and not a single tumor has returned.

DR. ROBINSON, of New York, said that he could substantiate all that Dr. Sherwell stated in regard to his case, and the effect of the treatment pursued; also as regards the nature of the tumor. He stated that he had treated several cases of sarcoma and many of malignant epithelioma by the internal administration of arsenic, but not with very beneficial results. The last one treated was a round-celled sarcoma, several inches in diameter, arising from the left parietal bone. The patient took from twenty to sixty drops of Fowler's solution every day for several weeks without producing any effect on the size of the tumor. Those cases of multiple sarcomata, with disappearance of some of the growths while new ones arise, indicate, in his opinion, that the lesions are inflammatory new growths, and not true tumors, with an origin from latent embryonic elements.

DR. SHERWELL stated that in the early future he thought arsenic will be more used in the treatment and prophylaxis of malignant and pseudo-malignant affections, and that in some of these affections the combined internal and hypodermic method will be found most useful.

The Hypodermic Use of Hydrargyrum Formamidatum in Syphilis.—By DR. R. B. MORISON, of Baltimore.

Discussion.

DR. CORLETT, of Cleveland, stated that he had used hypodermic injections of mercury in a number of cases. Each injection contained from one-eighth to one one-fourth grain of corrosive sublimate in a three-per-cent. solution of the chloride of sodium. The objection to the plan is the pain which follows, lasting several hours. As to results, he saw no advantage over other modes of administration, excepting in cases where the stomach would not tolerate its ingestion by the mouth.

DR. KLOTZ said that the important question in regard to the hypodermic injection of mercury in syphilis is the frequency of the relapses after that method compared with other methods of treatment, and the difference in the effects of the preparations used. Dr. Morison's experience on this point is about the same as that published by others; namely, that the effects of the soluble salts are neither very strong nor very lasting, the hydrargyrum formamidatum being among the least reliable mercurial salts. For several years back, Dr. Klotz said, he has seldom used the soluble salts for injection, because they offer no great advantages over the internal treatment. In the more severe cases he prefers the injections of the insoluble salts, which are much more effective and reliable.

THE PRESIDENT stated that he considered the hypodermic method of treatment often very valuable to fall back upon in those cases which have taken

mercury and potassium iodide until the stomach is in a state of rebellion and will not take any medicine. He thought some of Dr. Morison's cases would have improved as quickly under thorough daily inunctions as they did under the hypodermic injections. An artificial papular dermatitis is occasionally started by the use of mercurial inunctions, but that can be obviated by changing your ground.

A Case of Lichen Scrofulosorum.[1]—By DR. J. GRINDON, of St. Louis.

Discussion.

DR. ROBINSON stated that he had several cases of this disease, the last one being the case reported by Dr. Gottheil. In this case, which was a well-marked one, the lesions were situated upon the abdomen: they were markedly grouped, pinhead size, elevated, firm, with some circulatory disturbance a the periphery, but no lesions showing a suppurative process as in acne. He considered the clinical characters sufficiently peculiar to entitle the eruption to a special name.

DR. ZEISLER stated that during a long stay at Kaposi's clinic, at Vienna, he had only seen three or four cases, and in the last seven years he had only oberved one case in this country. This one was classical, and the simultaneous occurrence of numerous scrofulous ulcers around the neck, in the axillæ, groins, etc., made the diagnosis very easy. Dr. Zeisler does not consider the eruption in itself as evidence of tuberculosis, for it is a lichen in an otherwise scrofulous subject: not a lichen scrofulosus, but a lichen scrofulosorum.

DR. SHEPHERD said that he had only seen one case. That was reported ten years ago. The patient had the eruption on the extremities as well as on the body. There was also a well-marked scrofulous diathesis, with enlargement of the cervical lymphatic glands. The patient recovered when her general condition was improved by the use of cod-liver oil, internally and externally.

DR. CORLETT stated that he had only seen one typical case, and that was at Kaposi's clinic about two years ago. In this case the abdomen was specially involved, as were the anterior aspects of the thighs. In this country he has seen cases suggestive of the disease, but not typical. They were, he believed, cases of keratosis pilaris.

DR. FOX stated that he presented a typical case of acne cachecticorum to the New York Dermatological Society a year ago, in which there were groups of lichen scrofulosorum occurring on various portions of the trunk. In most of the cases he has seen there was marked evidence of a scrofulous diathesis. Dr. Fox said he did not like the name lichen scrofulosorum, but he did not consider it would be advisable to make a change, unless we were all agreed as to the precise meaning of the word "scrofula," and should adopt the word "scrofulo-derma," as used by the French.

DR. GRINDON said he wished to call attention to one point. As he understood it, the typical lichen scrofulosorum always appears in the same way. In the case he had reported, the eruption had appeared when the girl was twenty years of age. It appeared on the back, and very much resembled the picture given by Dr. Gottheil in the description of his case in the *Journal of Cutaneous and Venereal Diseases*. The eruption in that case was distributed both anteriorly and posteriorly.

[1] Will be published in this JOURNAL.

SECOND DAY.

The first order of the day was the report of the Committee on Statistics, by Dr. Hyde, of Chicago, chairman.

The reading of the report was followed by a discussion on tuberculosis of the skin. The following papers on the subject were read :

The Clinical Aspects and Relations of Cutaneous Tuberculosis.—By DR. J. C. WHITE, of Boston.

The Pathology of Cutaneous Tuberculosis.—By DR. J. T. BOWEN, of Boston.

The Treatment of Cutaneous Tuberculosis.—By DR. G. H. FOX, of New York.

Discussion.

DR. ALLEN, of New York, stated, in regard to treatment, that he has used scarification in a number of cases with good results. Several cases have been considered cured, and have remained well up to the present time. He has used the combined treatment of pyrogallol and emplastrum hydrarg. with a good deal of success during the past year. With regard to Koch's lymph he has had some experience, but nothing very positive. In one or two cases some improvement was noted after its use ; and in one case of tuberculosis of the hand and arm in a young Polish Jew local injections produced a very severe inflammation, and a good deal of cellulitis followed. Dr. Allen thought there is a future for Koch's lymph if properly used.

DR. ZEISLER stated that his observation of the results of the treatment of lupus with the galvano-cautery, in the service of Professor Besnier, of Paris, convinced him of its splendid action. He also wished to say a few words in defence of the silver-nitrate treatment. If the silver nitrate is used as a pointed stick, it answers in every respect the purpose of the destruction of the lupus nodules. It really acts as a knife as well as a caustic, and will enter the diseased tissue in any direction. His limited observation of the use of Koch's lymph has not impressed him favorably.

DR. BRONSON stated that he felt disposed to differ with certain of the ultimate conclusions drawn in Dr. White's paper. While it may be admitted that the tubercle bacillus plays an important part in all the diseases enumerated, he believed nevertheless that they are independent forms of disease, and should be so recognized. Though the presence of the tubercle bacillus may be an important factor in the etiology of all of them, it is not the only one that should be considered. There are other elements in the etiology of sufficient importance to give rise to distinct clinical forms, and determine different species of disease, if not different genera. Dr. Bronson said he did not believe that lupus could be produced at will by inoculations of the skin with the tubercle bacillus : other conditions are requisite ; that the affections known as tuberculosis cutis, scrofuloderma, tuberculosis verrucosa cutis, and lupus are interchangeable : that one can develop from another. With regard to the treatment, so far as concerns the influence of tuberculin in lupus, however, his experience does not fully agree with that of Dr. Fox. He has found that in some cases, after the inoculations, the lupus tubercles were softened and more readily operated upon by the curette. In most cases the gain had been far too slight to counterbalance the dangers of the treatment. Since his attention was called to the dental burr by Dr. Fox, he has used

it in many cases, especially where there were deep-seated tubercles, and with the greatest satisfaction.

DR. HYDE stated that it was a source of no small satisfaction to him that Dr. White had accepted a view which he (Dr. Hyde) had presented many years ago to this body. He reported on a group of lupus cases, calling attention to the fact that in many being in the first decade of life there was a reasonable probability that local infection had occurred. In this group of cases he tried to show that in the majority there was no history of tuberculosis or consumption in the family. We do see the coincidence of lupus vulgaris and pulmonary tuberculosis in this country, but that is rare; yet we recognize the fact that lupus vulgaris is tuberculosis. As to treatment, Dr. Hyde said he did not use the multiple linear or any other form of scarification. He habitually uses the curette and silver nitrate. He has not been favorably impressed with the results of tuberculin in these cases.

DR. DUHRING said he was unable to agree with Dr. White in classing all these diverse clinical manifestations as tuberculosis of the skin. With our present knowledge of the subject, the old terms must be retained, at least for some time to come. The speaker said he agreed perfectly with Dr. Bowen's view of the pathology of the disease, as put forth in his admirable paper, but he did not think that we should discard terms with a well-defined clinical significance. We need the term lupus vulgaris to-day, and we need equally the term lupus erythematosus. In regard to treatment, he desired to speak in terms of commendation of pyrogallol, and especially the mode of its application; he prefers to employ it in the form of an adhesive plaster, made up with resin cerate and soap plaster, in the strength of about three drachms of resin to one drachm of soap, to which is added the necessary amount of pyrogallol. By using it in the form of a continuous plaster, we get beneficial effects more surely than in any other form. Corrosive sublimate treatment he has employed without any beneficial results, the effect of it being rather to irritate the skin. The speaker has had several cases under observation during the past six or eight months which have been treated with tuberculin with varied results, which he regards as fairly encouraging.

DR. MORROW, of New York, said that he did not agree with the gentlemen who took exception to the broad generalization or classification recommended by Dr. White. We all recognize that etiology is the most scientific basis of classification; and if we admit the etiological identity of this class of diseases, it is perfectly legitimate to include them in the same category. We are all agreed as to the principles upon which a rational treatment should be based. The only question is as to the choice of the agent or method. Certainly just as brilliant results have been demonstrated in the treatment by scarification which Dr. Fox condemns as has been obtained from pyrogallol and other remedies. Dr. Morrow said that as far as his personal experience goes, he has for a number of years employed scarification, with the subsequent application of mercurial plaster, which he regards as an important element in the treatment. Many surgeons oppose the use of bloody scarifications, on the ground that absorption of the lupus products may lead to systemic infection. This possible danger may be entirely obviated by the use of igneous scarifications. Dr. Fox has spoken in high terms of the use of the dental burr in the treatment of small, disseminated nodules or points, which are so characteristic of lupus. The speaker said that in his opinion the best method of treating these minute, isolated nodules is their destruction by

punctate scarification. If the point of a galvano-cautery instrument is heated to a white heat and inserted into the nodules, it destroys absolutely the lupus tissue, and the extent of the destructive action can be accurately limited. As regards the use of caustics, he considers the chloride of zinc as, perhaps, the best caustic if we wish to use an agent for that specific purpose. It is certainly vastly superior to pyrogallol. Dr. Morrow said that he did not consider that pyrogallol had any specific or selective action on lupus tissue, or that it possessed more advantages in its treatment than other caustics. He thought that in the future excision would occupy a very much more prominent place in the treatment of this disease than other methods, since it is quite possible that sound tissue can be grafted in the place of the diseased skin, leaving a scarcely discernible cicatrix.

DR. ROBINSON said he must agree with Dr. Duhring and Dr. Bronson that the disuse of the term lupus is not advisable, for, although the etiological factor is the same in all, yet the clinical characters are so distinct that a further distinctive name is advisable. In skin diseases an etiological nomenclature and classification will never prove satisfactory as a whole, although it may answer in certain diseases. As regards treatment, we are still far from the goal to which we should strive. When the life conditions of the organism in all its bearings are well understood, we will find the means to make the ground unfavorable for their existence, or destroy them directly without the use of either caustics, scraping, or cutting.

DR. KLOTZ said that with a bacillus of so frequent occurrence and such general distribution as the bacillus tuberculosis, the possibility of the accidental seconday infection of previously existing lesions of the skin is certainly quite obvious, and it seemed to him that, whenever the bacillus tuberculosis is found in any neoplasm of the skin, we have to consider it as an affection of tuberculous origin—certainly as long as this question has not been studied more carefully.

DR. BULKLEY, of New York, stated that his experience in the treatment of lupus has been principally with the fine curette, so that the smallest points can be operated upon. He has tried wiping out the cavity with carbolic acid, after scraping, but found that the lupus still preceded him and that the onward progress of the disease was not checked. The matter of internal treatment has been mentioned, and here, he thought, we must look for the real cure of the disease. He has for many years employed a remedy which seems to be but little known, although he has advocated its employment on several occasions; namely, the use of phosphorus internally, carried to the point of tolerance. He believes that when patients are under this remedy, local measures give far better results. The nodules heal up under the treatment. In regard to scarification, he is not in favor of it, although he has seen it employed with apparent advantage, succeeded by the application of fuchsin, in a case of lupus at the Skin and Cancer Hospital. Pyrogallol he employs in powder, applied directly to the surface after scraping. He has used salicylic acid with good results, combined with powdered pyrogallol; that is, twenty-five per cent of salicylic acid to the powdered pyrogallol, rubbed together and applied as a powder to the surface. As regards tuberculin, he must proclaim himself sceptical as to whether it is really of any advantage in the treatment of this disease.

DR. SHERWELL said that in his opinion it is a question whether the bacilli occasionally or sparsely found in these neoplastic growths were causes or

simply effects; whether this group of diseases represented bacillary infection at all. Considering the immense amount of pulmonary tuberculosis that exists everywhere, it is curious that the particular form lupus or tuberculosis of the skin should be so relatively rare, and that it should appear so often in young and to all appearances fairly healthy persons. Personally, his clinical experience did not bear out the assertion that pulmonary tuberculosis is common in patients affected with lupus. In regard to the therapy, surgical and other, of lupus, he is inclined to believe that there is not nor will there ever be one fixed treatment. Removal of the neoplasm and improvement of the general health are demanded, and this would be best accomplished by different means in different individuals. He wished to inquire about one point in Dr. Bowen's paper and that is, Does not acceptance of Dr. Baumgarten's description of the origin of some of the cells he has mentioned seem somewhat like retrograde pathological histology, going back from Cohnheim to Virchow?

DR. WHITE, in reply to the criticism upon his paper, stated that his remarks were to the effect that he would not allow theory, without positive evidence, to stand any longer where we have closer methods of experimentation to fall back upon or to take the place of deductions. With regard to the French writers, we know that they long ago claimed that tuberculosis was of a scrofulous character, as well as lupus. The only question is, how they were authorized to do so on evidence then in existence which would stand the test of close examination. In reply to Dr. Bronson's remarks, Dr. White stated that the clinical differences that existed between these various forms of tuberculosis of the skin, which we have been so long considering as distinct affections, were no wider apart than the various expressions of syphilis or leprosy, which we do not find it necessary to distinguish by titles which indicate that they are more than forms of one disease. We should have one common generic title to include all forms of tuberculosis. In regard to what Dr. Hyde and Dr. Duhring have said about finding lupus in non-tubercular families, what has been stated has been based on positive and not on negative evidence, and it by no means excludes the fact that we may discover other modes of infection hereafter. As to treatment, Dr. White said he still adheres to the use of salicylic acid and corrosive sublimate. He has on record many cases in which there has been no recurrence of the disease after their use.

DR. BOWEN, in reply to Dr. Sherwell's inquiry, said that it is now pretty generally believed that the elements of the tuberculous neoplasm were derived from fixed tissue cells, and not from the leucocytes, as was believed before Baumgarten's experiments. The only authority he knew of who did not speak confidently is Klebs, who considers that it has not yet been proven that the epithelioid and giant cells are derived in all instances from the tissue cells. With regard to the forms of cutaneous tuberculosis, we may confidently assume for them the same histogenesis, and this view is supported by the recent work of Unna.

THIRD DAY.

Notes of a Visit to the Leper Hospital at San Remo, Italy, with Photographs. DR. L. A. DUHRING, of Philadelphia, read a paper with this title.

Notes on a New Method of Skin-Grafting.—By DR. P. A. MORROW, of New York.

Discussion.

DR. WHITE inquired of Dr. Morrow whether the deeper sections which he inserted were as likely to succeed as the grafting of the epidermal layers alone.

DR. MORROW replied that he thought the deeper grafts would be more certain to take. He had made more than fifty deep grafts in different cases, and never had a single failure, union always occurring promptly. He believes that the success of the operation depends upon the perfect coaptation of the graft with the surrounding tissues, and that the true skin, taken in its entire thickness, is more likely to be successfully implanted or engrafted than the epidermal layer.

The Treatment of Alopecia Areata.[1]—By DR. P. A. MORROW, of New York.

A Therapeutic Note on Alopecia Areata.[2]—By DR. L. D. BULKLEY, of New York.

Discussion.

DR. ZEISLER stated that if we objectively consider a large number of cases of this disease, we get the impression that in many of them the trouble is due to parasites, and we also note that almost all forms of treatment consist in the use of some parasiticide. Again, we meet with more formidable cases which clearly point to a neurotic origin, in which a general alopecia ensues in spite of treatment. As for treatment, he had used pilocarpine, but considered it rather dangerous. He regarded a concentrated solution of common salt as a good remedy for stimulating the growth of the hair.

DR. CORLETT stated that his observations as to the etiology of alopecia areata had been negative. In treating the disease, his object is to produce local irritation, and for this purpose he prefers a blistering fluid, such as cantharidal collodion. Chrysarobin he regards as a disagreeable application to use on the scalp, and one liable to do injury if carelessly used. He has not observed any good results from the use of Besnier's formula of acetic acid. Recovery often takes place spontaneously.

DR. GRAHAM, of Toronto, stated that he was surprised to hear Dr. Morrow's remarks upon the contagiousness of the disease, and that, while he had seen a number of such cases reported, he was still sceptical upon that point.

DR. MORROW replied that so many cases are on record demonstrating the contagion of alopecia areata, that he considers that point beyond reasonable doubt. Eichhoff reports ten cases in which contagion was definitely traced to a certain barber. Besnier reports a large number of cases in which proof of contagion was established beyond all question.

DR. DUHRING said that he doubted the contagious nature of the disease, as well as its parasitic origin. He saw nothing in favor of the parasitic nature of genuine alopecia areata, but everything is against that theory—clinical, etiological, and microscopical. As for treatment, he had great faith in the value of arsenic.

DR. WHITE stated that he considered the etiology of alopecia areata as still in doubt. We have yet to discover the parasitic germ. In treating these cases, he has seen good results follow the use of croton oil with oil of

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[1] Page 381. [2] Will be published in this JOURNAL.

turpentine, half a drachm of croton oil to eight ounces of turpentine. In some cases this remedy failed. He has also tried, with varying success, chloroform, acetic acid, pilocarpine, blistering, and electricity. In conclusion, Dr. White said that he did not believe there was any specific treatment for alopecia areata: that all the remedies act by their stimulating character.

DR. STELWAGON, of Philadelphia, stated that while the reported epidemics of alopecia areata by competent observers has suggested to his mind the idea that there must be two types of the disease—the contagious and the non-contagious—he has not yet seen two cases occur in one family, nor has he been able to trace a case to any possible source of contagion. In the treatment, local stimulation must be relied on. Pilocarpine he has employed without effect. Arsenic he gives as a matter of routine. His favorite method of treatment is the external use of a rubefacient composed of equal parts of oil of turpentine, tincture of cantharides, and tincture of capsicum.

DR. HYDE stated that he believed the time would come when we shall regard the condition to which we now give the name of alopecia as a surface symptom produced by a number of causes. In the majority of cases he considers that there is a neurotic origin, while in a relatively small number of cases it is probably due to a parasitic origin. As for treatment, every man has his own favorite method. In making a prognosis, the age of the patient is very important: after a certain period of life, no treatment, either local or general, will prove effective.

DR. KLOTZ said that he had seen one case in which hereditary syphilis was probably the underlying cause, the boy getting better under specific treatment.

DR. ALLEN, of New York, stated that he has for many years believed in the parasitic origin of alopecia areata. Two cases in the same family in his experience had pointed to contagion. As to the treatment, he has had good results from naphthol.

DR. SHERWELL believed that true alopecia areata has its cause in an essential neurosis. He distrusted the statistics in which epidemics of scores and even hundreds of cases are recorded, even by eminent observers.

DR. GRINDON, of St. Louis, said he felt satisfied that alopecia areata was only a name standing for different conditions. He has never met with a case that suggested either a parasitic or contagious origin; on the other hand, there was something to lend color to a theory of nervous causation in every case coming under his observation.

DR. MORROW said that he was surprised at the amount of therapeutic nihilism exhibited by the members. He had stated in his paper that a small contingent of cases of alopecia areata very clearly indicated a nervous origin, and that there are two types of the disease, each possessing a distinct etiology. The failure of parasiticides to cure the disease in every instance does not prove that it is not of parasitic origin. If the disease were invariably due to changes in the nerves, that fact has not been demonstrated. In many examinations made by Leloir and others, no evidences of peripheral or central nervous lesions were discovered.

DR. BULKLEY, in reply to a question, stated that he applied a 95-per-cent. solution of carbolic acid to a small portion only of the scalp at a time. It should be brushed over lightly at first, so as to benumb sensibility, and then rubbed in more thoroughly. He had not used it elsewhere than on the scalp. The skin is red for a few weeks; this disappears and the hair grows. He

also adminsters strychnine and phosphoric acid, and keeps up the nutrition of the patient.

Xeroderma Pigmentosum was the title of a paper read by DR. R. W. TAYLOR, of New York, illustrated by a water color-drawing.

The Etiology of Pruritus.—By DR. E. B. BRONSON, of New York.

Discussion.

DR. ZEISLER said that he had heretofore looked upon pruritus as a well-defined disease, in which there is originally no lesion noticeable. As far as the implication of the hair is concerned in the production of itching, he did not think it essential. The palmar surfaces are often the seat of excessive itching.

DR. MORROW inquired whether Dr. Bronson maintained that the essential seat of pruritus is in the nerves which supply the epidermis.

DR. BRONSON replied that he maintained that point.

DR. MORROW stated that there is a point in connection with pruritus that had interested him very much in its relation to leprosy. The pruritic symptoms of leprosy, especially in the earlier stages, have not been fully recognized or appreciated by observers. Patients in the earlier stages of leprosy, long before any lesions exist on the surface, suffer from a marked pruritus, varying in degree, and this pruritus is the most common and characteristic feature of the beginning stage of the disease. So far as we know of the pathology of leprosy, the essential changes are not in the nerves which supply the epidermis, but in the peripheral nerve trunks, and the primary seat of the pruritus must be sought for in some structural change, either in the cutaneous distribution of the nerves or in the peripheral nerve trunks.

DR. BRONSON said that in pruritus the primary trouble may and very frequently is central, but the expression of this trouble takes place at the periphery, or in the nerve terminals in the epidermis.

Diseases of the Skin Associated with Derangement of the Nervous System.—By DR. W. T. CORLETT, of Cleveland.

Discussion.

DR. BRONSON stated that neuropathic diseases of the skin are always interesting, because of the anomalous appearances they often present, and the difficulty that exists to refer them to any of the recognized types of skin diseases. It occurred to him that in the cases reported by Dr. Corlett, some of them might be classified without special reference to any neuropathic cause.

Treatment of Chronic Ringworm in an Institution for Boys.—By DR. L. A. DUHRING, of Philadelphia.

Discussion.

DR. FOX stated that he had used chrysarobin in a number of cases of ringworm, and could indorse what Dr. Duhring had said. He disliked greasy ointments and applications. The first point in the treatment is to clip the hair close; the second is to shave the patches, and often the whole head, and have the head scrubbed frequently with soap and water. Then apply chrysarobin in collodion to the smaller patches. Another satisfactory rem-

edy which he has employed is hydro-naphthol plaster, which can be used of varying strength according to the amount of the inflammation. Epilation he regards as a tedious method of treatment, but there are cases where it must be resorted to.

DR. ZEISLER advocated pyrogallol as a parasiticide.

DR. SHERWELL stated that in spite of some of the obvious objections to the use of oily preparations, oils must be considered among our best parasiticides, especially when plentifully used.

DR. DUHRING, in closing the discussion, stated that he did not consider chrysarobin a safe remedy to use in general or dispensary practice. As to epilation, it requires a good deal of time, and in the most chronic cases it is regarded as impracticable. On the other hand, in the most acute cases he found it useful.

Epilation: Its Range of Usefulness as a Dermato-therapeutic Measure.[1] —By DR. J. ZEISLER, of Chicago.

Discussion.

DR. FOX said he was glad to hear a man speak of the value of epilation in sycosis—a remedy which he thought had almost become obsolete. The speaker said he found the application of sulphur and tannin, in the form of an ointment, of advantage in certain cases after the use of the epilating forceps, but in sycosis epilation is of so much importance in treatment that it certainly ought to be mentioned first. He had seen cases of sycosis, however, in which even the most persistent epilation failed to produce a cure in a reasonably short time, and in such cases he would recommend internal or diathetic treatment.

DR. KLOTZ stated that Dr. Zeisler had mentioned the favorable effects of epilation in impetiginous eczema, and he might well extend it to several other affections, particularly to syphilitic papulo-pustules and ulcers on the scalp and other hairy parts like the lips, scrotum, and penis; likewise to chancres and chancroids in such localities. In these cases the constant formation of crusts retards or prevents the healing, and only by removal of the hair can the crusts be avoided. In regard to sycosis, Dr. Klotz stated that he has met with cases which did not heal during epilation, but were afterward cured without it, as well as others which were cured without any epilation at all, particularly since he has employed an ointment composed of one-half to one part of naphthol, three parts of precipitated sulphur, and thirty parts of zinc ointment.

DR. DUHRING stated that his experience with epilation, more especially in sycosis, has been that the pain is so great that the patient generally will not tolerate the operation. He has employed epilation with good results in some instances; sometimes more inflammation than previously existed was set up. Concerning epilation in alopecia areata, in chronic cases, such as dermatologists generally meet with, there is usually a perfectly bald surface and no hairs to epilate.

DR. MORROW, in reply to Dr. Duhring's criticism, stated that there could be no question of the absurdity of epilating the smooth, polished surface found in alopecia areata. His practice was to cut the hair close around the

[1] Page 444.

patch, embracing a certain margin ; and the hairs in this zone of protection, as it has been termed, were subjected to what might be called tentative traction or modified epilation. There is a general uniformity of opinion that the diseased hairs are always found around the margin of recent alopecic patches. As to the pain complained of by patients, it depends a great deal upon the skill and quickness of the operator. If the hair is grasped and a moderate or sluggish traction is brought to bear upon it, there may be considerable pain, while if there is a quick, sudden movement it is usually extracted without very much pain,

DR. STELWAGON, of Philadelphia, stated that no one could doubt the value of epilation in these several diseases. He has not found it so essential in simple sycosis, daily or frequent shaving taking its place. A remedy which has given good results in a number of cases is Vleminckx's solution; it is to be used diluted with five to ten parts of water, gradually increasing the strength and stopping just short of irritation. A mild ointment is employed from time to time to counteract the dryness and scaliness produced by this wash.

DR. HYDE said that he regarded the process of epilation as an exceedingly important one, although he never employs it in sycosis of the upper lip. In the public clinics abroad, when a case of alopecia areata is presented, the hairs in the periphery are in every case plucked out or plucked at, as if to establish the diagnosis.

DR. ALLEN stated that from his first experience in treating cases of alopecia areata he has noticed the looseness of the hairs in the periphery in patches, and that he has always practised epilation.

DR. DUHRING stated that in his remarks he had referred to chronic cases of alopecia areata. In the acute cases, where the hair is still falling, hairs are of course more or less loose at the margins of the patches; but when the process has existed for months or years, the remaining hair about the patches are generally firmly seated and healthy, and these are the cases we are usually called upon to treat.

DR. ZEISLER, in closing the discussion, said he wished to say one word as regards the pain incident to epilation. It all depends on the way in which the operation is done. The object of removing well-fixed hair around a patch of alopecia areata is to prevent the disease from spreading. As soon as the hairs are removed, the pustules dry up and the swelling of the skin goes down.

FOURTH DAY.

Molluscum Contagiosum.[1]—By DR. J. E. GRAHAM, of Toronto.

Discussion.

DR. BOWEN, of Boston, stated that there are still many authorities, among them Kaposi, who deny that these tumors are transmissible. and who still believe that they are modified sebaceous glands. The latter view is untenable. as there can be no doubt that the process consists in a proliferation of the rete cells downward into the corium; a benign epithelioma, and wholly unconnected with the glandular structures. As to what the cell forms found in this epithelial growth are, is doubtful. Neisser, a most competent microscopist, is quite convinced that they are a form of animal organism, but he

[1] Will be published in this JOURNAL.

has not yet been able to cultivate them. The speaker said he had not the slightest doubt as to the contagiousness of the affection.

DR. ALLEN had no doubt about the contagiousness of the disease, and related cases coming under his observation in an asylum, spreading from one case. Excision is never necessary. The nodules can readily be squeezed out, and then lightly touched with a caustic. He believed in their parasitic origin.

DR. E. WIGGLESWORTH, of Boston, stated that he desired to add one item of personal experience in regard to the contagiousness of the affection. In one case he had followed the plan just spoken of by Dr. Allen, and squeezed out the contents of the molluscous bodies between his thumbs. In the course of a very few days he noticed several of these little tumors upon his hands and forearms. Since then he has been in the habit of squeezing them with the pincers, and making sure of no relapse by the use of silver nitrate.

DR. WHITE stated that, granting the contagiousness of the disease, it does not follow that these corpuscles are the element of contagion. We should be very cautious about accepting as satisfactory any evidence which now exists with regard to the independent nature of these organisms.

The PRESIDENT stated that he did not question but that the mollusca are contagious. He never thought excision necessary, and does not even squeeze out the bodies, simply taking a sharp pencil of nitrate of silver and boring into them.

Note Relative to Pemphigus Vegetans.[1]—By DR. J. NEVINS HYDE, of Chicago.

Discussion.

DR. DUHRING said that he had had the opportunity of seeing the case described by Dr. Hyde. It certainly was more of the nature of pemphigus than of anything else.

DR. BOWEN had seen one of Neumann's cases in Vienna, which this one brought back very vividly to his mind. He has always considered the term pemphigus a very indefinite one, and thought that it gave very little idea of the pathology of the disease.

DR. SHERWELL had seen a case in a woman, with analogous symptoms, which was cured by ovariotomy.

DR. GRAHAM related the history of a similar case coming under his observation. It became much better under arsenic, but suffered a relapse.

DR. HYDE then closed the discussion. In reply to Dr. Sherwell he stated that in his case there was no disease of the ovaries. As to the name, he believed that some consideration was due to the man who first recognized the special character of the disease, and gave it the name he thought best. The micro-organisms recognized after culture experiments were not characteristic in appearance.

A Study of Mycosis Fungoides, with Report of a Case.[2]—By DR. H. W. STELWAGON, of Philadelphia.

Discussion.

DR. HYDE congratulated the author upon his excellent paper, and referred to the spots which precede the characteristic tumors and other features of the disease.

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[1] Page 412. [2] Will be published in this JOURNAL.

DR. HARTZELL stated that with regard to the nature of the infection it was still a matter of doubt. Future investigations must be in the direction of inoculation and culture experiments rather than in the way of microscopical examinations of the organisms which may be found.

DR. BOWEN spoke of the disagreement among pathologists in regard to the exact nature of the tumors.

DR. DUHRING stated that as a result of his observation he considered the disease as a general one of the skin, and not a local one; also that the involvement of other organs than the skin did not take place. It bears some resemblance in its course to lepra.

DR. STELWAGON, in closing the discussion, stated that the disease is not so uncommon as one would think. The disease usually begins in one of two ways—either as an erythematous or eczematous eruption, lasting from several months to a number of years.

Lymphangioma Circumscriptum, with Report of a Peculiar Case.—By DR. M. B. HARTZELL, of Philadelphia.

Discussion.

DR. STELWAGON spoke of the confluent nature of the vesicles in the case reported by Dr. Hartzell.

DR. BOWEN inquired whether in the cases reported there occurred (1) a proliferation of the blood-vessels in connection with lymphangioma; (2) an angiomatous process.

DR. HARTZELL replied that in the majority of cases there was an increase in the blood-vessels, but not in all cases.

Remarks on a Carbuncle, with Report of a Peculiar Case.[1]—By DR. H. G. KLOTZ, of New York.

DR. BOWEN spoke of the fat columns of Warren in this connection. These, he thought, had not received the recognition which their importance warranted.

Erythema and Nævus Nuchæ.—By DR. CHARLES W. ALLEN, of New York.

A Case of Lichen Ruber.[1]—By DR. J. GRINDON, of St. Louis.

Discussion.

DR. ZEISLER was inclined to view the case reported as one of lichen planus. He regretted the great confusion still surrounding the lichen group, and suggested that a better classification should be made.

DR. SHERWELL considered that the case reported was one of lichen planus, with exceptional features. In all true cases of lichen ruber, he said, the patients go from bad to worse, eventual marasmus and death being constant.

DR. WHITE said the case did not meet his view of lichen ruber, nor yet wholly of lichen planus.

DR. HYDE stated that he always found polygonal outline and so-called umbilication of the papule in the cases coming under his observation; he considered this a characteristic of our American lichen planus which does not seem to be familiar to European observers.

DR. DUHRING considered the case to be an atypical one of lichen planus.

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[1] Will be published in this JOURNAL.

The polygonal shape and umbilication of the papules may be absent in some of these cases.

Dr. Grindon, in closing the discussion, stated that he called his case one of lichen ruber because he thought it did not correspond to the description of lichen planus. The peculiarities were the persistent presence of the lesions about the face, their not making their appearance on the extremities for so long a time, and the involvement of the nails.

The association then adjourned.

Book Reviews.

Congrès International de Dermatologie et de Syphiligraphie tenu à Paris en 1889. Comptes Rendus publiés par le Dr. Henri Feulard, Secrétaire-général. Masson, Paris, 1890.

This volume of Transactions is most creditable, both to its editor and to those who took part in the proceedings of the Congress. It is to be commended for its fulness. On looking over its 950 pages one is impressed with the idea that what was said by each of the distinguished gentlemen present has been fully reported. The matter, too, is of great value to all who are interested in dermatology and syphilis, because such live questions are discussed as the lichens, pityriasis rubra, bullous diseases, trichophytosis, the treatment of syphilis, the frequency of tertiary syphilis, mycosis fungoide, pruritus hiemalis, etc. It contains also a list of the members of the Congress, which is open to the criticism that most of the first names are omitted; an appendix containing a number of papers by absent members of the Congress; a full and well-arranged index; and five full-page chromo-lithographs, three of a case of spontaneous keloid; one of the pathological anatomy of a case pityriasis rubra, and one of relapsing scarlatiniform erythema.

The volume as a whole is marked by that elegant neatness so characteristic of French publications and of all that comes from the press of M. G. Masson.

G. T. J.

EDITORIAL CHANGE.

Owing to the press of other professional duties, the senior editor will retire from his connection with this Journal with the issue of the present number, which completes the ninth volume.

With the opening of the new volume, Dr. John A. Fordyce, who has been actively associated in the management of the Journal for the past three years, will assume the sole editorial control.

No change will be made in the publication department, and no effort or expense will be spared by the Editor and Publishers to maintain the high standard of scientific and artistic excellence which has distinguished the Journal in the past.

INDEX.

A bit of personal experience of the value of arsenic. L. Duncan Bulkley, M.D., 452.

A new form of rhinoscleroma, 277.

A peculiar exanthem following an attack of epidemic influenza (with chromo-lithograph). W. L. Munro, M.D., 241.

A short notice in regard to the treatment of rodent ulcers with Unna's resorcin plaster mull, 230.

A study of mycosis fungoides, with report of a case. Stelwagon, 480.

A therapeutic note on alopecia areata. Bulkley, 475.

Abortive treatment of blennorrhagia, 303.

Abortive treatment of herpes, 231.

Absorption of medicaments in the form of ointments, 240.

Acne varioliformis on the extremities. Bronson, 33.

Acnitis, a form of general disseminated folliculitis and perifolliculitis, 304.

Action of guaco in pruritic affections of the skin, 118.

ALEXANDER, S. Septic infection following urethral operations. Report of case, 56.

Case of papillary adeno-carcinoma of bladder removed by supra-pubic cystotomy, with observations upon the diagnosis of small papillary fibroma of the bladder, 86.

Case of vesical and prostatic calculi formed upon nuclei of bone as result of necrosis of pelvis and perforation of bladder, 210.

Some remarks on the diagnosis of gonorrhœa in the male. No. 1, 284; No. 2, 376.

An observation upon the treatment of epididymitis, 455.

Alkalies in universal pruritus. Lange, 400.

Alopecia neurotica, 154.

American Dermatological Association, 359, 467.

American Association of Andrology and Syphilology, 360.

An anomalous case of alopecia for diagnosis. Jackson, 189.

An interesting case of inherited syphilis. Wm. L. Stowell, M.D., 215.

An observation upon the treatment of epididymitis. S. Alexander, M.D., 455.

An unusual case of sarcoma involving the skin of the arm; amputation; relapse. Shepherd, 467.

Anthropometry in the study of syphilis. Kobylin, 398.

Antidotal and bactericidal properties of fresh urine. Terry, 352.

Antisepsis of the urethra. Petit and Wasserman, 351.

Aristol, 360.

Aristol in venereal and cutaneous diseases, 227.

Arsenic as a drug. Hutchinson, 349.

Atrophy of the extremities followed by symmetrical ulceration of the legs. Morrow, 298.

Balsam of Peru in lupus and venereal ulcers, 229.

Bassorin Paste: A new base for dermatological preparations. George T. Elliot, M.D., 48, 99.

BOOK REVIEWS.

A Dermatological Bibliography compiled by George Thomas Jackson, M.D., New York. Presented to the American Dermatological Association and is-

Book Reviews.
sued as a part of its transactions for 1890, 272.
A Practical Treatise on Diseases of the Skin. Henry G. Piffard, A.M., M.D., assisted by Robert M. Fuller, M.D. With fifty full-page original plates, and thirty-three illustrations in the text, 270.
A Practical Treatise on Impotence, Sterility, and Allied Disorders of the Male Sexual Organs. Samuel W. Gross, A.M., M.D., 159.
Annual report of the Supervising Surgeon-General of the Marine Hospital Service of the U. S. for 1890, 320.
Atlas der Cystoskopie. Dr. Emil Burckhardt, 356.
Congrès International de Dermatologie et de Syphiligraphie tenu à Paris en 1889. Comptes rendus publiés par le Dr. Henri Feulard, secrétaire-général, 482.
Die Blennorrhöe der Sexualorgane und ihre Complicationen. Dr. Ernest Finger, 356.
Dei Morbi Sifilitici e Venerei. Roberto Campana, 79.
Die Litteratur über die venerischen Krankheiten, von den ersten Schriften über Syphilis aus dem Ende des 15. Jahrhunderts bis zum Jahre 1889. J. K. Proksch, 355.
International Atlas of Rare Skin Diseases. Edited by Malcom Morris, P. G. Unna, H. Leloir, and L. A. Duhring, 158.
Ointments and Oleates, especially in Diseases of the Skin. John V. Shoemaker, 80.
Pathologie et Traitement des Maladies de la Peau. M. Kaposi. Traduction, avec notes et additions, par MM. Ernest Besnier et Adrien Doyon, 353.
Some Urinary Disorders Connected with the Bladder, Prostate, and Urethra. Reginald Harrison, F.R.C.S., 159.
Book Reviews.
Traité Descriptif des Maladies de la Peau. Leloir et Vidal, 320.
Transactions of the American Dermatological Ass'n, 120.
Ueber die Behandlung von Lupus, Lepra, und anderen Hautkrankheiten mittel Koch'scher Lymphe ("Tuberculin"). Prof. M. Kaposi, 357.
Wood's Medical and Surgical Monographs, 119, 198, 320.
Books and journals received, 199, 357.
Brewer, G. E. The contagiousness of chronic urethral discharges, 81.
Bronson, E. B. Notes on certain pustular diseases attended with atrophy, 121.
Brown, F. T. The ocular and tactile demonstration of urethral lesions by the aid of new instruments, 245.
Buccal blennorrhagia in the newborn. Dohrn, 395.
Bulkley, L. D. A bit of personal experience of the value of arsenic, 452.

Calculi in the prepuce. Andrews, 218.
Carcinoma lenticulare — cancer en cuirasse (Velpeau)—report of a case. M. B. Hutchins, M.D., 181.
Cases of lesions of the genitals, female and male. (Illustrated.) R. W. Taylor, M.D., 201.
Case for diagnosis. Bronson, 142, 223.
Case for diagnosis. Bulkley, 187.
Case for diagnosis. Cutler, 31.
Case for diagnosis. Klotz, 66, 222.
Case for diagnosis. Robinson, 295.
Case of chancre of the conjunctiva. Andrews, 217.
Case of atrophia maculosa et striata following typhoid fever. (Illustrated.) F. J. Shepherd, M.D., 59.
Case of universal erythema multiforme. L. A. Duhring, M.D., 421.
Case of excision of stricture and urethroplasty for radical cure. E. L. Keyes, M.D., 401, 428.
Case of multiple dermoid cysts simulating xanthoma tuberosum. S. Pollitzer, A.M., M.D., 281.
Case of the erythematous type of dermatitis herpetiformis. Elliot, 139.

Case of lichen scrofulosorum. Grindon, 470.
Case of severe joint affection following gonorrhœa. Mauriac, 439.
Case of lichen ruber. Grindon, 481.
Case of tuberculosis of the glans penis, with remarks concerning the conveyance of tuberculosis through sexual intercourse. Kraske, 343.
Case of Addison's disease with atrophy of the supra-renal capsules, 305.
Case of actino-mycosis of the face. Darier and Gautier, 342.
Case of late syphilitic epididymitis. J. D. Thomas, M.D., 292.
Case of non-tropical chyluria, 74.
Case of purpura due to a streptococcus, 156.
Case of retarded constitutional syphilis not transmitted to the offspring 77.
Case of leprosy treated by Koch's lymph. Allen, 141.
Case of Morvan's disease, 155.
Clinical study of pruritus hiemalis, winter itch, frost itch, etc. William T. Corlett, M.D., 41.
Contribution to the surgical treatment of ruptures of the bladder. Cabot, 429.
Cause of death following extensive burns and a possible antidote for the same. Lustgarten, 224.
Cerebral syphilis, 318.
Certain diagnostic features of cutaneous syphilis. Fox, 102.
Chancres of the fingers: their clinical history, their complicating septic infections, etc. Taylor, 65.
Chancre of the thigh. Klotz, 298.
Chancre of rectum. Hartley, 128.
Chronic enlargement of the testicle, 232.
Chronic ulcers treated by massage, 117.
Clinical notes on (*a*) hypertrophy of the prostatic sphincter, (*b*) relation of combined percussion as a diagnostic auxiliary in tumors of the abdomen, 39; relation of rectal distention to arterial depression. Belfield, 434.
Concerning the time and cause of the extension of gonorrhœa to the pars posterior urethræ. Heisler, 440.
Concerning the condition of sexual susceptibility and its deficiency (anaphrodisia) in coitus, 35.
Concerning new remedies employed in the treatment of cutaneous affections, particularly as substitutes for iodoform, 311.
Congenital syphilis. Stowell, 217.
Ceresole Reale water in diseases of the skin, 380.
CORLETT, W. T. A clinical study of pruritus hiemalis, winter itch, frost itch, etc., 41.
CORRESPONDENCE.
Dermatology and syphilography in France. Brocq, 107, 191, 299.
Molluscum bodies and polarized light. S. Pollitzer, 71.
Wilson on the nature of molluscum bodies. Jos. Grindon, 146.

Dactylitis tuberculosa. Fordyce, 71.
Danger of cocaine in urethral surgery. Glenn, 352.
Dermatitis hæmostatica. Hermann Klotz, M.D., 361, 467.
herpetiformis. Bulkley, 190.
papillaris capillitii. (Illustrated.) Bronson, 188.
Dermatological notes. George Thomas Jackson, M.D., 337.
Diabetes and syphilis. Sourouktchi, 352.
Diffuse idiopathic atrophy of the skin. Groen, 399.
Disease of the hand. Bronson, 224.
of the nails. Klotz, 297.
Diseases of the skin associated with derangements of the nervous system. Corlett, 477.
DUHRING, L. W. A case of universal erythema multiforme, 421, 468.

Electric cataphoresis in the treatment of dermato-mycoses, 229.
Electroplaters' eczema. Allen, 294.
Electro-puncture in chronic hydrocele, 38.

Elliot, G. T. Two cases of intra-uterine ichthyosis, 20.
Bassorin, a new base for dermatological preparations, 48.
Pseudo-pigmentary lesions on the hands of millers, 206.
Two cases of dermatitis herpetiformis developing after severe mental emotion and shock, 321.
Encysted stone, complicated with growths of bladder. Mastin, 432.
Epidemic zoster, 198.
Epilation: Its range of usefulness as a dermato-therapeutic measure. Zeisler, 444, 478.
Epithelioma of penis. Allen, 67.
of the nose treated by Bougard's paste and pyoktanin. Allen, 184.
Ergotin in gonorrhœa, 240.
Excision of the bladder, 360.
of the chancre as an abortive treatment of syphilis, 274.
Exhibition of new instruments. Otis, 428.
of complete double ureters of both kidneys. King, 436.
of an antiseptic syringe for hypodermic medication. White, 248.

Folliculite décalvante. Bronson, 69.
Fordyce, J. A. Multiple pigmented sarcoma of the skin (Kaposi), 1.
Peripheral neuritis of syphilitic origin, 174.
Microscopic examination of Dr. Bronson's case of acne variolioformis of the extremities, 128.
Furunculosis, 116.

Genital chancres in women. Taylor, 425.
Gonococci. Vibert and Bordas, 353.
Gonorrhœa in women. Currier, 219.
Gonorrhœal meningitis and optic neuritis. Panas, 351.
Hæmaturia. Otis, 433.
Hard chancre of Eustachian tube, 73.
Hereditary syphilitic transmission through two generations. King, 427.
Herxheimer's spirals in the epidermis, 156.
Hutchins. Carcinoma lenticulare; cancer en cuirasse (Velpeau), 181.
Hyde, J. N. Note relative to pemphigus vegetans, 412, 459.
Hygiene of syphilitics, 301.

Ichthyosis cornea (hystrix) partialis, 155.
Infections (syphilitic) and their dangers in surgical and obstetrical practice. Taylor, 65.
Inflammatory stricture of the ureters. Francis S. Watson, M.D., 407.
Irish moss plasma as an ointment base. Fox, 224.

Jackson, G. T. Dermatological notes, 337.

Keratoma. (Illustrated.) Piffard, 144.
Keyes, E. L. A case of excision of stricture and urethroplasty for radical cure, 401, 428.
Klotz, H. Dermatitis hæmostatica, 361, 467.
Koch's cure for tuberculosis, 39.
method in lupus. Effects of the lymph in other affections, 112.

Late serpiginous syphilide. (Illustrated.) Allen, 71.
Lichen ruber treated by tuberculin, 272.
Long incubation of chancre and tardiness in the appearance of secondary manifestations, 195.
Loomis, H. P., and Fuller, R. M. Report of a case of lupus vulgaris treated with Koch's tuberculin, 134.
Lupus. Henry G. Piffard, M.D., 161.
erythematosus of the face. Jackson, 297.
vulgaris treated with Koch's lymph. Death thirty-six hours after an injection of two milligrams, 115.
erythematosus. Bronson, 143.
of the nose. Allen, 410.
by inoculation, 152.
of the hand. Allen, 185.
of the nose and upper lip. Allen, 141.

Lupus vulgaris, in its relation to tuberculosis. James C. McGuire, M.D., 264.
vulgaris, 118.
Lustgarten, S. On psorospermosis follicularis, 7.
Lymphangioma circumscriptum, 278, circumscriptum, with report of a case. Hartzell, 481.

Malleus humidus, 196.
McGuire, J. C. Lupus vulgaris in its relation to tuberculosis, 264.
Microscopic examination in Dr. Bronson's case of acne varioliformis of the extremities. (With two plates). J. A. Fordyce, M.D., 128.
Molluscum contagiosum. Allen, 32. contagiosum, Graham, 479.
Morrow, P. A. The treatment of alopecia areata, with cases, 381, 475.
Morphœa on the abdomen. Sherwell, 297.
Multiple pigmented sarcoma of the skin (Kaposi). J. A. Fordyce, M.D., 1.
pigmented sarcoma of the skin. (Illustrated). Morrow, 145.
sarcomata. History of a case showing modification and amelioration of symptoms with large doses of arsenic. Sherwell, 468.
epithelioma of the face; erysipelas with consecutive retrogression of the epithelial growths; absence of glandular affection, 119.
myomata of the skin, 152.
Munro, W. L. Peculiar exanthem following an attack of epidemic influenza, 241.
Pemphigus foliaceus malignus, 332.
Pemphigus malignus; the sequel, 423.

Nephrorrhaphy, 75.
New York Dermatological Society, 30, 66, 99, 139, 184, 222, 294.
Notes on certain pustular diseases attended with atrophy (with plate). Edward Bennet Bronson, M.D., 121.
Note on a bromide eruption and on annular tubercular syphilide. Robt. W. Taylor, M.D., 441.
Note relative to pemphigus vegetans. James Nevins Hyde, A.M., M.D., 412, 459.
Note on a new method of skin grafting. Morrow, 474.
Note upon a possible service to be expected from diuretin in genito-urinary surgery. Keyes, 432.
Notes on surgery of the prostate. Wishard, 434.
Notes of a visit to the leper hospital at San Remo, Italy. (With photographs.) Duhring, 474.
Note on erythema et nævus nuchæ. Allen, 481.
Note relative to pemphigus vegetans. Hyde, 412, 459, 480.

Oberländer, Dr. On chronic prostatitis, 261.
Observations upon the surgery of the ureter. Cabot, 435.
upon the syphilitic cachexia. White, 427.
On a papular acneiform eruption, with colloid masses resembling those found in molluscum contagiosum. Payne, 399.
On the occurrence of herpes zoster during the administration of arsenic, 153.
On syphilis of the external ear. Adolph Rupp, M.D., 366.
On the use of salicylic acid in the treatment of certain forms of cystitis. Bryson, 431.
On chronic prostatitis. Dr. Oberländer, 261.
On phthiriasis of the pubis, 277.
On psorospermosis follicularis. Dr. Sigmund Lustgarten, 7.
On the occurrence of nephritis in syphilis. Fordyce, 427.
On ichthyol varnishes, 197.
On the radical cure of urethral stricture by restoration of the mucous membrane to a healthy condition. Bryson, 436.
On the tendency to flush as a cause of morbid changes, 304.

Otis, W. K. To render the introduction of litholapaxy tubes less difficult, 29.

Papular syphilide and seborrhoic eczema. Elliot, 186.
Pemphigus foliaceus malignus. W. L. Munro, M.D., and G. T. Swarts, M.D., 322.
malignus; the sequel. W. L. Munro, M.D., and T. L. Swarts, M.D., 423.
Peripheral neuritis of syphilitic origin. J. A. Fordyce, M.D., 174.
Persistent dandruff, acne, and seborrhœa of Unna, 117.
Piffard, H. G. Psorospermosis, 14.
Lupus, 161.
Pigmentary syphilides, 316.
Pollitzer, S. Case of multiple dermoid cyst simulating xanthoma tuberosum, 281.
Preliminary programme of the American Association of Andrology and Syphilology, 280.
programme of the American Dermatological Association, 279.
Prescriptions for hyperidrosis, 360.
Prescription for painful affections of the skin, 360.
Primary tuberculosis cutis by inoculation, 197.
Prophylaxis of syphilis for nurses and nurslings, 302.
Prostatics and their treatment. Guyon, 348.
Prurigo of Hebra. Elliot, 222.
Sherwell, 185.
Pseudo-pigmentary lesions on the hands of millers. (Illustrated.) George T. Elliot, M.D., 206.
Psoriasis resembling eczema seborrhoicum. Bulkley, 298.
or eczema. Fox, 67.
Psorospermosis. Henry G. Piffard, M.D., 14.
in the rabbit's liver. Malassez, 396.
Purpura due to the diplococcus pneumoniæ, 316.
hæmorrhagica, 276.

Rectal distention, relation to arterial depression. Belfield, 434.
Recurrent macular syphilide ten months after infection. Bulkley, 30.
Reflex irritations and neuroses caused by strictures of the urethra in the female. Otis, 424.
Reinfection of syphilis, 233.
Remarks on carbuncle, with report of a peculiar case. Klotz, 481.
Removal of the third lobe of the prostate. Complete restoration of the function of the bladder, 237.
of an eight-ounce vesical calculus by the supra-pubic route, 38.
Report of a case of papillary adenocarcinoma of the bladder removed by supra-pubic cystotomy, with some observations upon the diagnosis of small papillary fibroma of the bladder. (Illustrated.) Samuel Alexander, A.M., M.D., 86.
of a case of lupus vulgaris treated with Koch's tuberculin. (With plate.) Henry P. Loomis, M.D., and R. M. Fuller, M.D., 134.
of a case of vesical and prostatic calculi, formed upon nuclei of bone as the result of necrosis of the pelvis and perforation of the bladder. (Illustrated.) Samuel Alexander, A.M., M.D., 210.
of a case of papillary adeno-carcinoma of the bladder. Alexander, 102.
of a case of universal erythema multiforme. (With colored portrait and specimen.) Duhring, 421, 468.
Resorcin plaster mull, 230.
Results of the Koch method in lupus, 146.
Retinol in psoriasis, 360.
Rötheln. Robinson, 296.
Rupp, A. On syphilis of the external ear, 366.

Salicylate of mercury in gonorrhœa, 240.

Septic infection following urethral operations—report of a case. Samuel Alexander, M.D., 56.
SHEPHERD, F. J. Case of atrophia maculosa et striata following typhoid fever, 59.
Solutio calcii bisulfurosi as used in Unna's clinic, 116.
So-called circumscribed atrophy of the skin after secondary syphilis. Oppenheimer, 369.
Some remarks upon the diagnosis of gonorrhœa in the male. No. 1. (Illustrated.) Samuel Alexander, M.A., M.D., 284; No. 2, 376.
STOWELL, W. L. Interesting case of inherited syphilis, 215.
Sub-ungual keratosis. Cutler, 101.
Sulphur in variola, 78.
Suppuration from drug applications in skin diseases, 156.
Syphilis of abnormal evolution, 314.
of the lung, 273.
Syphilitic arteritis, 313.
diseases of the spinal column. Jasinski, 396.
immunity. Hudelo, 339.

TAYLOR, R.W. Cases of lesions of the genitals, female and male, 201.
Note on a bromide eruption and on annular tubercular syphilide (Illustrated), 441.
Tertiary ulceration of the nose. (Illustrated.) Piffard, 101.
The abortive treatment of erysipelas, 397.
administration of mercury to syphilitic infants, 315.
applicability of the electro-urethroscope, 235.
commencement, duration, and method of treatment in syphilis, 195.
difficulties of diagnosis of syphilitic reinfection, 157.
dry poultice in the treatment of epididymitis. Brewer, 436.
ancient treatment of syphilis. Feullard, 342.
modern treatment of syphilis. Hutchinson, 390.
The diagnostic value of hæmaturia in affections of the genito-urinary organs. Sturgis, 64.
JOURNAL illustrations — editorial, 160.
hypodermic use of hydrargyrum formamidatum in syphilis. Morison, 469.
American Association of Andrology and Syphilology, 424.
female urethra: a source of trouble often overlooked in our gynæcological investigations, 119.
contagiousness of chronic urethral discharges. George Emerson Brewer, M.D., 81, 105.
influence of clothing on the skin, 117.
ocular and tactile demonstration of urethral lesions by the aid of new instruments—shown with cases. F. T. Brown, M.D., 245.
curability of Parrot's disease, 315.
methodic treatment of gonorrhœa. Thiery, 344.
frequency of affections of the posterior urethra in gonorrhœa, 225.
occurrence of microcytes in bloody urine, 226.
rule of conduct to be observed when one is consulted by a nurse relative to a syphilitic nursling, 111.
pathological anatomy of psoriasis, 154.
primary cause of death following burns of the skin. Lustgarten, 397.
significance of the figures described as coccidia (psorosperms) in epitheliomata, 157.
seborrhœic wart, 154.
value of atropia in enuresis, 72.
stone disease in Russia, 276.
relations of colloid milium, colloid degeneration of the skin, and hydradenoma to each other, 153.
relation of sexes, 73.
sublimated-ether spray in the treatment of small-pox vesicles on the face, 76.

The therapeutic effect of diuretin. Geisler, 440.
treatment of alopecia areata—with cases. Prince A. Morrow, M.D., 381, 475.
treatment of acne in both sexes by relief of genital irritation—a generalization of Sherwell's method. J. M. Winfield, M.D., 93.
treatment of grave forms of syphilitic parenchymatous keratitis, 303.
treatment of non-operable cancers by means of interstitial injections of pyoktanine, 276.
treatment of pruritus. Bronson, 477.
treatment of skin diseases by the use of Dr. John Chapman's method of cold to the spine. Kinnear, 101.
treatment of urethral stricture and its resulting conditions by extreme gradual local distention and without cutting; including a brief *résumé* of fifty cases. Tuttle, 437.
use of tuberculin in the treatment of lupus, and also some new agents in the therapy of lupus, 312.
usage of drying liniments in the treatment of skin diseases, 310.
Thomas, J. D. Case of late syphilitic epididymitis, 292.
To render the introduction of litholapaxy tubes less difficult. William K. Otis, M.D., 29.
Treatment of lupus with Koch's lymph at the Hôpital Saint-Louis, Paris. Communication of M. le Dr. Besnier, 191.
of local tuberculosis by the injection of oil of creosote in large doses, 299.
of urethral stricture. Bangs, 437.
of enuresis, 237.
of chronic ringworm in an institution for boys. Duhring, 477.
of condylomata, 307.
Treatment of circumscribed patches of psoriasis, 278.
of alopecia areata, 318.
of scleroderma by electrolysis, 110.
of leprosy with oil of chaulmoogra and gynocardic acid, 301.
of sycosis, 240.
of non-syphilitic vegetations of the external genital organs, 239.
of tuberculosis by the method of Koch, 107.
of gonorrhœa. Glenn, 439.
of urticaria, 231.
of the chancroid, 231.
Tuberculin in leprosy, 305.
Tuberculosis verrucosa cutis. Fordyce, 142.
Tubercular syphilide of the forehead. Robinson, 297.
Tuberculosis, cutaneous, discussion on, 471.
Tuberculous testicle, 360.
Tumor of the scrotum. (Illustrated). Gerster, 62.
Two cases of intra-uterine ichthyosis. George T. Elliot, M.D., 20.
cases of dermatitis herpetiformis developing after severe mental emotion and shock. George T. Elliot, M.D., 321.

Undetected stone. Hingston, 431.
Urticaria from the sulphate of quinine, 308.
pigmentosa in an adult. Elliot, 296.
pigmentosa. Goldenberg, 189.

Watson, F. S. Inflammatory stricture of the ureters, 407.
Why syphilis is not aborted by the early destruction or excision of its initial lesion, 317.
Winfield, J. M. Treatment of acne in both sexes by relief of genital irritation, 93.

Zeisler, Joseph. Epilation: Its range of usefulness as a dermatotherapeutic measure, 444.
Zur Aristolfrage, 230.

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